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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Before The Honorable Charles R. Breyer, Judge

THE CITY AND COUNTY OF SAN FRANCISCO, et al.,	)	
Plaintiffs,	)	
VS.	)	**NO. C 18-07591 CRB**
PURDUE PHARMA PHARMA, L.P., et al.,	)	
Defendants.	)	

San Francisco, California
Monday, April 25, 2022

TRANSCRIPT OF PROCEEDINGS

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United States District Court - Official Reporter

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Monday - April 25, 2022 **9:29 a.m.**

P R O C E E D I N G S

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THE CLERK: All rise. Court is now in session. The Honorable Charles R. Breyer now presiding.

You may be seated.

THE COURT: Would you call the matter, please.

THE CLERK: Calling Civil action C 18-7591, City and County of San Francisco, et al. vs. Purdue Pharma, et al.

Judge, do you want the attorneys to come forward?

THE COURT: They don't have to come forward, but simply announce yourselves from the --

THE CLERK: I turned their mics off.

THE COURT: Right.

-- from our tables.

THE CLERK: Okay. One moment.

THE COURT: But speak into the microphone. Let me remind people that this is being live streamed, and so it's helpful for those people who aren't in this courtroom and the court reporter to see you.

THE CLERK: So, plaintiffs' counsel, please state your appearance for the record and please speak into the microphone. Thank you.

MR. CHIU: Good morning, Your Honor. San Francisco City Attorney David Chiu appearing on behalf of the People of

the State of California.

THE COURT: Good morning, Mr. Chiu.

MS. EISENBERG: Sara Eisenberg, San Francisco City Attorney's Office, for the People of the State of California.

THE COURT: Good morning.

MS. BAIG: Good morning, Your Honor. Aelish Baig with Robbins, Geller, Rudman & Dowd for the People of the State of California.

MR. HEIMANN: And good morning, Your Honor. Richard Heimann also for the People.

MS. CONROY: Good morning, Your Honor. Jane Conroy, Simmons Hanly Conroy, for the People.

THE COURT: Good morning.

MR. MOUGEY: Good morning, Your Honor. Peter Mougey on behalf of the People of the State of California, Levin Papantonio Rafferty.

MS. CABRASER: Good morning, Your Honor. Elizabeth Cabraser, Lieff, Cabraser, Heimann & Bernstein, for the People.

THE COURT: Good morning.

MS. DO AMARAL: Good morning, Your Honor. Paulina Do Amaral, Lieff, Cabraser, Heimann & Bernstein, for the People.

THE COURT: Good morning.

MS. KARIS: Good morning, Your Honor. Hariklia Karis from Kirkland & Ellis on behalf of the Allergan defendants.

MR. HOWELL: Rich Howell from Kirkland and Ellis, also

on behalf of the Allergan defendants.

MS. KOSKI: Good morning, Your Honor. Katy Koski, Foley & Lardner, on behalf of the Anda defendant.

MR. MATTHEWS: James Matthews also here for Anda, Inc.

MS. WEST FEINSTEIN: Good morning, Your Honor. Wendy West Feinstein with Morgan Lewis for Teva, Cephalon, and the Actavis generic defendants.

MR. JAMES: Good morning, Your Honor. Collie James of Morgan Lewis on behalf of the Cephalon, Teva, and Actavis generic defendants.

MS. SWIFT: Good morning, Your Honor. Kate Swift for Walgreens.

MR. SWANSON: Good morning, Your Honor. Brian Swanson also for Walgreens.

THE COURT: Good morning.

Well, everybody, welcome. I'm pleased that we are finally starting this trial. Let me just make a couple of observations.

First of all, we are live streaming it because of COVID considerations, and also this district is part of a pilot project in connection with it's called The Cameras in the Courtroom Project. Several districts in the United States have agreed to participate in this.

You'll note that the cameras mercifully are not on me. That's that is for the good of the cause, but they are going to

focus on the two podiums, plaintiffs and defendants, as well as the witnesses.

And also we have a camera facility -- I don't quite know how it works -- actually, I don't know how any of this works -- to reproduce or broadcast or stream exhibits. So during the course of a witness' testimony or during the counsel's presentation, exhibits will also be visible outside the courtroom.

Let me just remind everyone who may be listening or participating in it, that the reproduction or the filming of screen shots is prohibited. And I expect that people will simply follow the protocols that have been established by the Judicial Conference, as well as this court, in the pilot project.

So, with that, let's -- let's commence with plaintiffs' opening statements. Today are plaintiffs' opening statements. Tomorrow are defendants' opening statements.

I want to remind everyone something that I'm sure I don't need to remind you of, is the fact that opening statements are expectations of what the evidence will show.

It's not evidence in and of itself; and, therefore, I would not expect any objections from any party because if, in fact, a party doesn't prove that which the party asserts it could prove, either because I don't permit it into evidence or there's a lack of evidence substantiated, it has no consequence

as far as I am concerned. It's simply an expectation. It is not evidence in and of itself.

So with that and the hope that we will move quickly, but, you know, but according to your intentions of presenting your case, we will turn first to the plaintiffs.

MS. SWIFT: Your Honor, with apologies. Kate Swift for Walgreens.

And appreciating everything that you just said, we do have a privilege objection to several of the slides in plaintiffs' opening statement. It's Slides Number 79 through 86.

Judge Polster in the MDL ruled on this objection. He overruled our claim of privilege. He said it was a very close call. We have consistently maintained the claim of privilege over those -- the documents in those slides.

THE COURT: So let me ask you this: There are two ways we can handle it, because I don't want to get embroiled in some dispute during the course of an opening statement.

One way -- and, by the way, I intend to do this, a failure to object during an opening statement is not a waiver of anyone's position. Okay. So that -- that's preserved. All your objections are preserved.

Now, if it's of a particular nature where it ought not to be -- not to be shown, I can ask that those exhibits simply be handed to the Court if that -- during the opening if that's the way you'd like to proceed.

I don't want to sit down and have a discussion of it at this point.

How do you want to proceed? Which way?

MR. HEIMANN: Well, my understanding, Your Honor, is that the objection has been overruled.

THE COURT: Oh. Do you mean I overruled them?

MR. HEIMANN: No, no, no. Not by Your Honor yet, but by the MDL trial judge, and --

THE COURT: Well, be that as it may, let's -- I don't want to now spend a lot of time figuring out what Judge Polster did.

How do you want to proceed? Do you -- do you have a concern if it's shown in the course of his -- in the course of his presentation?

MS. SWIFT: I believe I have to maintain the objection to it being shown in order to maintain the privilege.

THE COURT: So as a matter of law -- so would you not -- either not show them or simply those -- it's identified; is that right? You're aware of which --

MR. HEIMANN: I'll need to get the numbers.

THE COURT: Okay.

MR. HEIMANN: Again, but these are -- I want to emphasize these are important exhibits.

THE COURT: They can be shown to me.

MR. HEIMANN: Okay.

THE COURT: They can be shown to me.

MS. SWIFT: That's fine, Your Honor.

THE COURT: You know, as we said c'est moi. I mean, I can deal with it. Judges deal with it all the time, but I think that there is a concern if there's a privacy concern, so forth, that it be disseminated nationally, and I appreciate the defendants' position on that.

So show it to me. I'll let -- this is not your first rodeo. You figure out how you want to present it. Just don't show it to the -- don't live stream it. Okay?

MR. HEIMANN: I got that, Your Honor.

THE COURT: Great.

MR. HEIMANN: Can you tell me the slides?

THE COURT: Does that take care of it? Do you have the numbers --

MS. SWIFT: Yes.

THE COURT: -- and everybody is happy and --

MR. HEIMANN: It won't come until this afternoon so we will figure it out.

MS. SWIFT: Thank you, Your Honor.

THE COURT: All right. Clean slate. Go ahead.

MR. HEIMANN: Thank you, Your Honor.

OPENING STATEMENT

MR. HEIMANN: May it please the Court, my name again is Richard Heimann, and with Your Honor's permission I will be

sharing the opening statement with my colleague Ms. Baig, and we'll -- I don't want to say we'll tag team it, but I'll do the opening remarks and then she will be standing up next, and I will come back probably sometime this afternoon given the timing of how this thing works. Let me begin then.

There may be issues open to debate in this case, but about this there is no debate. We are in the midst of an opioid epidemic and that epidemic has had catastrophic consequences in San Francisco. It has been the cause of death and suffering for going onto two decades now.

Despite years of efforts by the City to stem the tide of death and suffering from addiction to opioids, the epidemic still rages in the City to this day.

You only have to walk a few steps from this courthouse to witness the effects of the epidemic, and that is why the People chose to bring this case before this court.

So while some issues may be open to debate, the fact of the epidemic and its impact in San Francisco is not debatable. Instead, the real questions before the Court are: How did this happen? Who is responsible? Who can and should be held accountable?

Many books and articles have been written that address these questions, but now those questions are before Your Honor for determination.

Patrick Keefe in his book ***Empire of Pain*** put it this way

(as read):

"The opioid crisis is, among other things, a parable about the awesome capability of private industry to subvert public institutions."

The defendants here are not the only ones who we concede are responsible for the opioid epidemic. There are others, actually many others, who share that responsibility.

For example, the Stanford Lancet Commission, a diverse group of scholars and experts, gathered together in an effort to review the history of the epidemic in order to identify the causes of the epidemic and at the same time to formulate ways to avoid the epidemic occurring again.

That commission in its report published in February put it this way (as read):

"The origins of the opioid crisis reflect substantial failures within the corporate sector, regulatory, and legislative bodies, the medical profession, and healthcare systems."

Although you will hear from the defendants that they deny responsibility, they will point the fingers at other actors, and they may be right.

Some of those actors do bear some responsibility; but in our view, the defendants in this courtroom are some of those who are indeed responsible and who we contend should be held legally accountable.

Again from the Stanford Lancet article (as read):

"Perhaps the most important fact to remember about the opioid crisis is that for some people it brought not suffering but enormous wealth. OxyContin alone is estimated to have generated revenues of over $35 billion for Purdue Pharma and its owners."

But while Purdue may be the starting point, it was far from alone. Other opioid manufacturers also reaped substantial revenue from soaring prescription rates.

And it wasn't just the manufacturers of opioids that profited. Many pharmaceutical distributors also profited handsomely while knowingly making astonishingly large shipments of pills which they were required to report to regulators but did not.

And profit seeking was not entirely external to the healthcare system. Some hospitals, clinics, pharmacies, professional societies, and individual healthcare professionals also enriched themselves.

Opioids and its addictive properties have been known to mankind for millennia, but the Twentieth Century -- by the Twentieth Century the nature of opioids was so well known by the medical community that opioids, if used at all, were only used for acute pain with short duration, for end-of-life care, and for cancer pain. All that -- all that began to change in the 1990s, however.

As good a place as any to start is with Purdue Pharma obtaining approval from the FDA for OxyContin in 1995 and the marketing campaign that followed.

As the Lancet article again provides, OxyContin was fraudulently marketed as less addictive than other opioids and, hence, is more acceptable to use for a broad range of indications and at high doses.

Backed by the most aggressive marketing campaign in the history of the pharmaceutical industry, OxyContin became the best known of a number of opioid medications whose prescription rate exploded in the United States.

But Purdue and OxyContin were followed by the introduction by other manufacturers of their own products: Watson, Actavis, Allergan, Endo, Teva, Insys, Mallinckrodt, to name just a handful.

And why was there such an influx of others into the opioid market promoting extensively for chronic pain? The size of the market and the potential profits to be made from expanding the market for opioids from acute short-term use, a relatively small market, to chronic long-term use for very common conditions like arthritis and low-back pain.

Here, for example, is the former CEO of Endo describing how and why Endo got into the market.

(Video was played but not reported.)

MR. HEIMANN: But how did they move the market? By

false marketing and promotion. Here is an early example from Purdue.

(Video was played but not reported.)

MR. HEIMANN: I'm going to emphasize the language there about the rate of addiction for patients undergoing opioid therapy is less than 1 percent. That will become a significant issue in the case as we move forward.

Anna Lembke, Dr. Anna Lembke, be our first witness. She's the author of the book *Drug Dealer MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard To Stop.*

Dr. Lembke is a Stanford psychiatrist and addiction specialist. She has testified before Congress regarding addiction and addiction treatment. She will testify here about addiction and how it works, and she will testify about how the opioid industry brought about a paradigm shift in the medical use of opioids.

Now, I mentioned that the method -- the means by which the opioid industry caused the paradigm shift was focused on false and misleading statements. Here are some of those statements that were used (as read):

"Addiction to prescription opioids is rare or virtually nonexistent in patients treated for chronic pain."

"Only addicts are at risk of addiction to prescription opioids."

"There is no clinical ceiling dose of prescription opioids."

"Drug seeking behavior is not a sign of addiction but, rather, a pseudoaddiction."

"Opioids are effective in treating chronic pain and should be used first line."

"Dependence is a benign and easily treated condition."

"Screening tools can identify who will become addicted."

And what were the means and methods by which these misrepresentations and misleading statements were communicated to the medical community and beyond?

A broad range, starting with aggressive sales force, drug representatives who actually meet with physicians in their offices in an effort to persuade them to take up opioids for use in chronic conditions, key opinion leaders and speakers bureaus that the manufacturing defendants had and used to speak to physicians across the country in an effort to persuade physicians to change their medical practices.

Funding front groups, such as the American Pain Society, and the American Academy of Pain Medicine, so that it would appear that independent groups were advocating when, in fact, those independent groups were largely financed by the manufacturers of opioids themselves.

Continuing medical education courses, coopting medical watchdog organizations, seeding the medical literature with flawed and biased studies, medical school curricula promoting opioids for off-label uses, targeting the highest prescribers of opioids in order to increase the sales of opioids, and, finally, free drug samples and coupons and vouchers.

The goal of the industry was to alter medical practice dramatically from what had been the conservative use of opioids for more than a century. The goal was to create a new market. As an example -- this is from the launch by Cephalon of a drug called Fentora in 19 -- excuse me -- in 2006.

(Video was played but not reported.)

MR. HEIMANN: Pain is the market that they created together. They created the market, the market for opioid drugs to be used for chronic and long-term periods.

And what was the consequence -- a consequence of all of this effort? The foreseeable consequence is increasing the supply of available opioids resulting in increased addiction and the opioid crisis of today.

Here, again, from the Stanford Lancet Commission their findings (as read):

"Departing from decades of medical practice in which opioids were used mainly for cancer, surgery, and palliative care, U.S. and Canadian regulators, physicians, and dentists expanded opioid prescribing to a broad range

of non-cancer pain conditions from lower-back pain to headaches to sprained ankles."

Opioid addiction was prevalent for more than a century before the current crisis began, but nothing in the drug history of the United States was remotely on the scale of the contemporary opioid crisis.

This level of opioid exposure has no historical antecedents worldwide. The widespread availability of pharmaceutical opioids also has no historical parallel.

In fact, as this graph shows, the sale of prescription opioids over the period from roughly 1999 to its peak in 2010 increased fourfold, and right along with that increase deaths increased in parallel from overdose; and, in addition, substance abuse, treatment admissions, in parallel with the increase in sales and use of opioids for long term.

And the same thing happened in San Francisco. This is a reflection of the shipments of opioids into San Francisco based on MME, morphine milligram equivalent, between the years -- the mid-'90s and the peak in 2010, a fivefold increase in shipments of opioids into San Francisco.

The opioid crisis came in three waves. The first wave involved prescription opioids and occurred at a time when the illicit markets in heroin were isolated and stable in much of the country.

The second wave beginning in around 2010, although it

varied a little bit depending upon which part of the country we're talking about, was fueled by the first wave and was instigated by drug traffickers realizing that individuals who had become addicted to prescription opioids were a fertile market for heroin.

The best-available data shows that some 80 percent of Americans who initiated heroin during this period started with prescription opioids.

The third wave beginning in around 2014, involved the addition to illicit opioid products of fentanyl, and this brought about a unprecedented fatality to the opioid crisis.

All three waves continue to this day.

The third wave was particularly catastrophic in San Francisco as this bar graph demonstrates. The increase in deaths from fentanyl skyrocketed.

The defendants will attempt to blame the problems in San Francisco, particularly the current problems, on fentanyl itself; but the evidence will show that there's a direct line between prescription opioids, heroin, and fentanyl -- a direct causal line between prescription opioids, heroin, and fentanyl.

The myths, the lies, the misleading statements, and the promotion by the opioid industry was a substantial cause of the opioid epidemic that we face today, but that epidemic should never have happened.

The claims regarding the safety and efficacy of

prescription drugs were false. They were false at the time they were made and not supported by reliable science at the time either that they were made or ever since.

The scientific reality is reflected here. Prescription opioids are as addictive as heroin. The best conservative data -- I come back to that less than 1 percent that you heard from Mr. -- the gentleman speaking for Purdue -- the best conservative data showing addiction prevalence of 10 to 30 percent among chronic pain patients.

The risk of overdose and death increases dramatically as the dose and duration are increased.

No reliable evidence shows long-term opioid therapy is effective for chronic non-cancer pain.

Any person, any person can become addicted regardless of prior abuse; and, again, the greatest risk factor for addiction to opioids is dose and duration.

Weaning addicted or dependent patients from opioids is often difficult and can take years to accomplish and in some cases is not possible at all.

Pseudoaddiction, a term that was used excessively by those promoting the use of opioids for chronic pain, is a made-up term. There's no empirical support for it. And there are no reliable screening tools to predict who will get addicted to prescription opioids.

I come back to Dr. Lembke. She will testify that when the

supply of an addictive drug is increased, more people become addicted to and suffer the harms of the drug.

She will testify that the defendants' conduct in her opinion promoting increased supply and widespread use of access to opioids, including through misleading messaging and unchecked distribution and dispensing, has resulted in the opioid epidemic of addiction and overdose death.

Today's opioid crisis would not have occurred without the paradigm shift substantially caused by the defendants and others in the pharmaceutical opioid industry.

I want to step back now in time, back to the 1970s, with the passage of the Controlled Substance Act by Congress and its signing into law by then President Nixon.

The purpose of that act in large part was to regulate the manufacture and distribution of dangerous drugs in the country to prevent illicit diversion of drugs.

Chief among the drugs that was of concern were those that were defined as Schedule II drugs, drugs with a high potential for abuse and with use potentially leading to severe psychological and physical dependence, including opioids such as oxycodone.

The act was intended to create a closed system for the distribution -- for the manufacture and distribution of Schedule II drugs. So the manufacturer to the distributor, the distributor to the practitioner or to the hospital or the

pharmacy, and ultimately to the actual patient.

The purpose of the closed system was to prevent diversion outside of the system, illicit diversion outside of the system, and the use of those drugs by persons other than those who were properly prescribed it for medical purposes.

And to that end, all participants in that closed system are required to register with the DEA. The primary aim, as I said -- or a primary aim -- was to prevent diversion outside the closed system, and Congress recognized that in enacting the Controlled Substances Act in 1970.

There are two critical aspects of the Controlled Substance Act with respect to diversion and with respect to the duties and responsibilities imposed on registrants that relate directly to the concern over potential diversion.

The first is the distribution phase, the transfer from the manufacturer to the distributor and the distributor to the retailer.

And the second is the dispensing stage, which primarily involves doctors prescribing controlled substances and then pharmacies filling those prescriptions to patients.

I'm going to start now with issues relating to distribution and hold the dispensing subject until we talk more deeply about Walgreens later today. Probably this afternoon.

The regulation 21 C.F.R. 1301 that I'm showing here provides that manufacturers and distributors are required to

design and operate a system to disclose to them suspicious orders of controlled substances.

Suspicious orders are defined to include, but are not limited to, orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency.

But the criteria is not exclusive. Characteristics of orders known to the distributor may indicate other reasons for suspicion and, importantly, the DEA did not and does not approve any particular ordering -- suspicious order monitoring system. It's up to the registrants themselves knowing their businesses and their customers to devise a system appropriate for their business model.

But whatever the business model, the obligations are really simple. They are: Identify suspicious orders, report suspicious orders to the DEA when discovered, conduct an independent investigation prior to filling an order that is deemed suspicious, and shipping that order only if the investigation dispels the basis for suspicion.

These statutory and regulatory requirements and duties have been in effect since the enactment of the Controlled Substances Act in 1970.

And the proof in this trial, the proof that we will present to Your Honor, will show that none of the defendants in this case, none of the defendants had an adequate system at any

time during the relevant time period.

None of the defendants fulfilled their duties and responsibilities as distributors under the Controlled Substances Act.

The DEA over time repeatedly informed the pharmaceutical industry of their legal obligations.

In 2006 and 2007, for example, the DEA sent letters to all DEA-registered distributors and manufacturers regarding their statutory and legal duties under the CSA and the regulations.

The first two letters in September 2006 and February 2007 began with (as read):

> "The purpose of the letter is to reiterate the responsibilities of controlled substance distributors in view of the prescription drug abuse problem our nation currently faces."

Let me emphasize that last point. By 2006 when these letters were sent by the DEA to the manufacturers and distributors, the epidemic that we're suffering from today was already raging.

Both of those letters described the statutory scheme and legal duties of distributors as DEA registrants: To maintain effective controls against diversion of controlled substances into other than legitimate medical, scientific, and industrial channels.

The registrant shall design and operate a system to

disclose suspicious orders of controlled substances to the registrant.

The registrant shall then inform the DEA of the suspicious orders -- tongue twister now -- when discovered by the registrant.

The letter also clearly stated the responsibility for designing that system and implementing a system and defined, again, suspicious orders to include those of unusual size, those deviating substantially from normal pattern, and orders of unusual frequency.

The regulation also requires that the registrant inform -- I'm sorry.

The third letter -- I skipped over, the third letter -- the first two letters were in 2006 and early 2007. The third letter was sent in December of 2007 and stressed that federal regulation requires the registrant to inform the DEA of suspicious orders when they are discovered.

And that will become important with respect to the conduct of a number of the defendants in this case including, importantly, Walgreens.

The letters went on to state that the regulation, as I mentioned a moment ago, clearly indicates that it is the sole responsibility of the registrant to design and operate the system.

The DEA does not approve or otherwise endorse any specific

system for reporting suspicious orders for the reasons that I mentioned before. It's up to the registrant to understand their business, their business model, and their customers.

I will return and Ms. Baig will return to a more fulsome discussion, Your Honor, of the failings of the distribution systems that were involved -- involving these defendants and -- when we address the liability case for each of the defendants.

But at this time let me give you some guidelines as to where we're intending to go from the balance of this opening statement forward.

We'll next discuss the legal claims in the case, the liability case against Teva, the liability case against Allergan and Actavis, and then the case against Anda and finally the case against Walgreens; and at the conclusion we will address specifically the scope of the nuisance, the impact of the epidemic in San Francisco.

At this point I will turn over the podium to Ms. Baig to continue. Thank you, Your Honor.

THE COURT: Do people want to stand up and just stretch a bit? I do. The jury wants to stand up, so...

(Laughter)

(Pause in proceedings.)

THE COURT: Okay. Please be seated.

MS. BAIG: Good morning, Your Honor.

THE COURT: Good morning.

OPENING STATEMENT

MS. BAIG: As my colleague, Mr. Heimann, explained earlier, I will lay out the legal claims as well as walk you through Allergan, Teva, and Anda's misconduct, which the People allege fueled the opioid epidemic in San Francisco.

(Pause in proceedings.)

MS. BAIG: As I know you are aware, the People assert a public nuisance claim against all of the defendants.

We allege and we believe the evidence will show that defendants' conduct, that their false, misleading and otherwise unfair marketing practices, along with their failure to identify, halt and report suspicious orders contributed to the creation of a public nuisance: The opioid epidemic in San Francisco.

The evidence will also show that the opioid epidemic is injurious to health. It is indecent or offensive to the senses and that it interferes with the comfortable enjoyment of life or property.

We only need to establish one of those elements, Your Honor. We intend to establish all three.

The People also assert an unfair competition law claim, a UCL claim, against Allergan, Teva, and Anda.

There are three ways to prove unfair competition. One can prove the business acts were unlawful, unfair, or fraudulent. We intend to prove all three.

Under the unlawful prong, the evidence will show that Allergan, Teva, and Anda violated the Controlled Substances Act by failing to identify, report, and halt suspicious orders and by failing to provide effective controls against diversion, which means the transfer of legally prescribed controlled substances from the individual to whom it was prescribed to another person.

It has been recognized by Congress as being a danger to the safety of the community.

The People have alleged that Allergan and Teva violated the Consumer Legal Remedies Act, which requires a showing that they engaged in unfair or deceptive acts or practices intended to result or which did, in fact, result in the sale of goods.

The evidence will show their unfair and deceptive acts were intended to and did, in fact, result in maximizing opioid sales.

Under the fraudulent prong of the UCL, the People need to establish that defendants' conduct was likely to deceive members of the public.

The evidence will show that defendants' promotion of opioids was not only likely to but designed to and, in fact, did broadly deceive members of the medical community and the public about the safety and efficacy of opioids for chronic pain for everyday use.

Under the unfair prong, the People need to establish that

the harm to the victim outweighs any benefit.

The evidence will show defendants' false, misleading, and unfairly aggressive promotion of controlled substances coupled with their utter failure to identify, halt, or report suspicious orders to the DEA certainly resulted in more harm than benefit to the People of the State of California.

Now, Your Honor, turning to the defendants Allergan and Teva, these are manufacturers who make and distribute a wide variety of morphine products.

Morphine beautifully described by Sam Quinones, author of *Dreamland: The True Tale of the American Opiate Epidemic* (as read):

> "Like no other particle on earth, the morphine molecule seemed to possess heaven and hell. It allowed for modern surgery, saving, and improving too many lives to count but," he says, "it stunted and ended too many lives to count with addiction and overdose."
>
> "No other molecule in nature provided such merciful pain relief and then hooked humans so completely and punished them so mercilessly for wanting their freedom from it."

This is the drug at issue. Morphine, derived from the seed pod of the poppy plant, comes from the fluid in the pod and has been known to be deadly for more than a century.

More than a century ago we understood the dangers of

opioids, and the evidence will show from the 1900s to the 1980s we were very conservative in our approach to opioids.

But with the 1990s became the beginning of a paradigm shift, and part of what prompted that shift, a large part, were the unfair promotional efforts of manufacturers, including Allergan and Teva.

Allergan, Teva, Anda, and Walgreens are the remaining defendants in this action. Allergan and Teva, the manufacturers. Anda is a distributor that was first owned by Allergan and then sold to Teva. Walgreens has acted as both a distributor and a dispenser.

I'll be talking with you about the manufacturers and Anda conduct and will turn it back over to my colleague Mr. Heimann who will address Walgreens.

Each of these defendants has a number of corporate entities which fall within their defendant family, and there are a great number of mergers and acquisitions which happened along the way.

Not to belabor things, but it will likely be important for you to understand at some level the merger history which I will explain here.

And this simply shows the generic drug company Watson acquired generic drug company Actavis Group, and then there were a couple of name changes. Watson changed its name to Actavis, Inc., in 2012.

And then Actavis, Inc., changed its name to Allergan Finance LLC; and finally Allergan Finance LLC's parent, Allergan PLC, sold its generic business to Teva in 2016 for $40 billion.

Distilled down to its essence, it's just this: Allergan Finance LLC, formerly known as Actavis, Inc., formerly known as Watson, sold some branded opioids, like Kadian and Norco, but was a generic drug company giant with many generic opioids.

And Allergan sold that generic drug business along with Anda, its in-house distributor, to Teva in 2016.

Before August of 2016, the giant generics business that resulted from the merger of Watson and Actavis Group belonged to Allergan.

Teva, prior to that sale, prior to acquiring Allergan's massive generics business, had its own profitable branded opioids, Actiq and Fentora, and some generic opioids as well.

It sold opioids in the U.S. prior to 2016 through Teva Pharmaceuticals USA and Cephalon, Inc.; and after 2016, it sold many more opioids through the Actavis generic entities it purchased from Allergan.

So Teva's corporate family includes, in relevant part, Teva Pharmaceuticals Industry, which is the parent corp in Israel, Cephalon, and Teva USA; and as of August 2016, the Actavis generics entities it acquired from Allergan.

What did these companies sell? The whole gamut in terms

of opioids, Your Honor. They sold the generic form of OxyContin, which is oxycodone HCL. They sold oxymorphone. They sold fentanyl. They sold many, many formulations of opioids.

And here we've broken Teva down for you by subsidiary. Cephalon sold Actiq and Fentora, both fentanyl products.

Teva sold generic OxyContin, oxymorphone, and others. A massive number of these pills were sold into San Francisco.

Allergan and Teva promoted opioids with both branded and unbranded marketing strategies, meaning that some of their promotional efforts came in the form of glossy brochures with brand names of an opioid drug splashed across the front or sales reps visits directly to prescribers' offices; but a lot of their promotional efforts, which we will get into, were more subtle than that and, yet, still worked phenomenally well.

We can't very well talk about marketing without first talking about the Food and Drug Administration's role in approving these drugs; and you will likely hear from defendants that because the opioids were FDA approved, they ought not to be held liable for selling them.

A few things on that, Your Honor. First, the FDA in approving these drugs relies on defendants to be honest about their drugs.

And, in any event, along with approval come very strict rules requiring that all marketing be truthful and not

misleading, meaning that defendants cannot understate the risks or understate the ben -- overstate the benefits.

Defendants cannot engage in misleading promotion under the guise of third parties.

Defendants cannot promote for unapproved or off-label uses.

The evidence will show that defendants did all of the above.

Indeed, former FDA Commissioner David Kessler has testified in a preservation deposition, Your Honor, that defendants departed from industry practice and standards that they were expected to adhere to.

How? By minimizing risks of abuse, by promoting opioids for off-label purposes, by understating the risks of addiction either themselves, through the use of key opinion leaders, or through collaboration with third-party pain advocacy groups and other professional, medical, and trade group organizations.

The evidence will show that OxyContin marketing began with Purdue and the Sackler family that owned it. It was incredibly lucrative, brought enormous success; and with success like that, the evidence will show many others, including defendants here, clamored onto the bandwagon marketing and selling opioids as a risk-free panacea for all kinds of pain.

And prescriptions and sales of opioids soared for all kinds of uses, nationally and in San Francisco.

But, again, Your Honor -- and I know my colleague Mr. Heimann raised this, it bears repeating -- that all of the opioids at issue here were Schedule II drugs, which by their very nature have a high potential for physical dependence and abuse.

And we ask that you keep in mind when evaluating whether the marketing and SOMS practices were fair, not only the false and misleading marketing, which we believe the evidence will show was obviously unfair, but the other practices as well, like motivating sales reps with incentive compensation, bonuses, contests, prizes; sales reps whose very livelihood is based on how much they sell. They are the ones tasked with educating prescribers about the risks of the drugs which were controlled substances?

There's an obvious tension, an obvious conflict there. This is a practice which is perhaps widely accepted for selling other products.

It may be fine for selling chocolate bars; but, Your Honor, the People will show that the way they did it here for highly dangerous controlled substances was unfair.

The sales employees tasked with educating doctors were also in charge of addressing first-line SOMS issues.

So the sales reps, again paid based on how much they sell, they are the ones tasked with addressing suspicious orders with the customers?

How many of those orders do you think they halted and reported if their compensation was based on maximizing sales?

THE CLERK: Judge, one moment, technical issue.

THE COURT: Okay, we need to re-start the computer so, hold that thought.

MS. BAIG: Okay.

(Pause in the proceedings.)

THE COURT: All set? Great. Thank you.

Go ahead.

MS. BAIG: The obvious inherent tension, Your Honor, made the practice unfair, but we do know the practices were highly effective and, tragically, we note that opioid use disorder and overdose deaths advance in lockstep with opioid sales.

By 2008, drug overdoses, mostly from opiates surpassed car accidents as a leading cause of accidental death in the U.S. By 2012, overdose deaths rose to one every half hour.

That's --

(Pause in proceedings.)

MS. BAIG: A strong summary of certain aspects of unbranded marketing, Your Honor, can be found in the December 2020 bipartisan Senate report issued by Senators Chuck Grassley and Ron Wyden, which illuminates the extensive connections between opioid manufacturers and nonprofit patient advocacy groups, professional provider groups, and medical

associations.

Your Honor, we ask that you read the Senate report. The report found that these groups sought to influence opioid-prescribing practices and related federal policy.

The goal of the investigation was to take a look at seemingly neutral pain advocacy organizations, like American Pain Society, American Society of Pain Educators, and the like, and identify the groups largest donors.

The investigation revealed that manufacturers here contributed to such organizations, and specifically that Teva led the way having paid over $4.8 million to organizations like the American Chronic Pain Association, the International Association of Pain; and in exchange, they received deep cooperation with their overall messaging about opioids.

The report expressed (as read):

> "We remain concerned that the opioid epidemic was driven in part by misinformation and dubious marketing practices used by pharmaceutical companies and the tax-exempt groups they fund."

Part and parcel of that sort of collaboration between opioid manufacturers and pain advocacy groups is the source of messaging found in the book ***Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families***.

And the evidence will show that Cephalon contributed to the American Pain Foundation. The American Pain Foundation

then published this book designed to reach out to veterans. And I'm going to read a passage from it (as read):

"Veterans who answered the call to service and who have endured grievous harm to body and soul deserve the best pain medicine available. The goal of ***Exit Wounds*** is to arm veterans and their families with the information and resources they need to advocate for the quality of pain treatment they deserve."

It goes on to state that (as read):

"The pain relieving properties of opioids are unsurpassed. They are today considered the gold standard of pain medications and so are often the main medications used in the treatment of chronic pain. Yet, despite their great benefits, opioids are often underused. For a number of reasons, healthcare providers may be afraid to prescribe them and patients may be afraid to take them. At the core of this wariness is the fear of addiction so I want to tackle this issue head on."

"Long experience with opioids shows that people who are not predisposed to addiction are unlikely to become addicted to opioid pain medications. When used correctly, opioid pain medications increase a person's level of functioning."

Here you have an example of pharma preying with their false marketing on one of their country's most vulnerable

populations.

Another example of unbranded marketing, manufacturers promoted the notion that pain ought to be assessed as the fifth vital sign and that prescribers should use a pain assessment tool like this one in every patient visit.

Pain is not a vital sign. It's not something that can be objectively measured. Dr. Lembke will testify that pain evaluators have never been shown to improve pain outcomes and do not add to understanding patient's pain, and she will also testify that such tools have been shown to increase opioid prescribing.

False and misleading statements came in both nonbranded and branded marketing forms. Defendants made statements to the effect that opioid addiction was rare.

Allergan trained every sales rep nationally, including those who came into San Francisco, with this false statement in its Kadian learning brochure (as read):

> "There is no evidence that simply taking opioids for a period of time will cause substance abuse or addiction."

This was false.

Now, defendants are likely to tell you that this document was only used internally but, Your Honor, it was used internally to train every single Allergan sales rep selling opioids nationally. Those same sales reps were then tasked with promoting not only branded Kadian but also generic

opioids, including generic Kadian, generic oxymorphone, and others.

The evidence will show that similarly for Teva, in all of its pain products learning systems in 2008, 2014, and 2017, including for Fentora, a fentanyl product, Teva trained sales reps that (as read):

> "Generally patients do not become addicted to opioids and that use of opioids rarely leads to addiction."

These statements were false, as our addiction specialist Anna Lembke, and other prescriber witnesses in San Francisco will aptly confirm.

Manufacturers also downplayed the risk of addiction by spreading the notion of pseudoaddiction, the idea that addictive behavior was really just your body telling you that you needed more pain relief and that your symptoms would disappear once you simply took more opioids, a convenient notion for someone trying to maximize sales of opioids.

Again, addiction specialist Anna Lembke will testify that there is no empirical support for the diagnosis of pseudoaddiction nor for the notion that more opioids is an appropriate response to patients exhibiting drug-seeking behavior.

Both Allergan and Teva promoted this notion of pseudoaddiction, which will be debunked by Dr. Anna Lembke and other physician witnesses with similar expertise.

Additionally, the evidence will show that manufacturers misrepresented that there was no dosing limit; that addictive behavior was really just your body telling you that you needed more pain medication.

Again, convenient if you're in opioid sales, but our addiction specialist Anna Lembke will testify that multiple studies have verified that the risk of overdose increases with higher doses and longer duration as does the risk of addiction.

And here you see both companies promoting the notion that there is no ceiling dose for opioids generally.

Keep in mind that the Allergan-Actavis family of defendants was the second-largest opioid manufacturer nationally and the largest opioid manufacturer in San Francisco. They sold more than 24.1 percent of all prescription opioids that came into San Francisco from 2006 to 2014.

The Allergan-Actavis marketing evidence will show that there was -- there were sophisticated, well-developed brand and generics marketing departments in place, that all marketing policies were national, the policies did not change state by state or city by city, and the national policies and practices were implemented in San Francisco.

It will also show that in 2010 the U.S. Food and Drug Administration, Division of Drug Marketing and Communications, DDMAC, sent Actavis a warning letter flagging false and

misleading misrepresentations made in Actavis' promotional materials for Kadian.

DDMAC warned that Actavis' promotional materials omit and minimize the serious risks associated with Kadian, broaden and fail to present the limitations to the approved indication of the drug, and present unsubstantiated superiority and effectiveness claims.

Despite being warned by DDMAC, the evidence will show that Actavis continued to market opioids with messaging DDMAC had found to be misleading.

The evidence will show that Allergan trained its sales reps with false and misleading messaging, that the sales force was tasked with selling brand and generic opioids, and trained with messages around the long history of safe and efficacious use, as well as the false messaging we just discussed, and that the marketing aggressively targeted high prescribers.

Jennifer Altier, marketing director at Actavis, trained all the sales reps with the Kadian learning brochure, which, as we've seen, was full of false and misleading statements about opioids downplaying the risk of addiction.

The evidence will also show that she used IMS data, which the company purchased precisely so they could track the highest prescribers in any given community, including in San Francisco, for marketing purposes.

And what did they do with this data? They set goals for

their sales reps. For example, 26,000 Kadian prescriptions per week. These goals, again, might be fine if you're selling a less dangerous product; but for highly dangerous controlled substances, this, along with the false and misleading marketing, is an unfair business practice.

And it wasn't just the brute force sales reps that were used to sell. They used, for example, techniques telesales to target the three highest prescribers, including in San Francisco.

They used Anda and McKesson telemarketing; and they used direct mail campaigns, trade journals, and several websites to target San Francisco healthcare professionals and pharmacies with their messaging.

You will likely hear from defendants that they don't market their generic drugs at all, but the evidence will show that Jinping McCormick, who was the director of generic marketing, marketed oxycodone, fentanyl patch, oxymorphone, generic Kadian, and others, and her compensation was also based on her ability to grow sales. She used all kinds of data: IMS; IQVIA data; chargeback data, which it received back from its customers; Wolters Kluwer data, Medi-Span data that allowed them to track their pills to the pharmacy and prescriber level for marketing purposes. And, yet, she couldn't remember ever using it for SOMS' purposes.

She also used multichannel marketing, volume incentive

programs, stocking incentives to pharmacies, all with the primary objective of growing sales of controlled substances additional.

Additional marketing strategies employed include collaborating with McKesson to make calls to the 500 highest dispensing pharmacies, hiring ad agencies for e-mail blasts to 90,000 pharmacists, direct mail campaigns to doctors, journal advertising, e-mail campaigns to pharmacies, all promoting oxymorphone in this example.

Notably, they even used Anda for telemarketing promotion through Anda's call center. And note that telemarketers are financially incentivized to promote oxymorphone. Even Walgreens had a marketing team to help Actavis grow oxymorphone sales.

Michael Perfetto, the vice president of sales and marketing, acknowledged, like everyone else, that performance is measured and compensation is based on how much is sold. We'll get deeper into SOMS in just a few minutes, but he also acknowledged that the SOM system in place was so inadequate they would need to, quote, "start from scratch" to bring it into compliance.

Debbie Webb was a top ten sales rep in 2011. She was a sales rep in San Francisco. She was trained with the misrepresentations in the Kadian learning system, and she was bonused for exceeding sales quota for opioids.

Same for Robin Hagy, another sales rep selling brand and generic opioids. She too was trained with the false messages and ordered marketing materials, including those found misleading by DDMAC, for use in her doctors visits.

Moving on to Teva marketing. The evidence will show that all told, Teva spent a good deal of time and energy on marketing. Teva's main drugs, Actiq and Fentora, both fentanyl products, were only approved for breakthrough cancer pain, BTCP; and, yet, 92 percent of prescriptions were for noncancer use.

How did that happen? While it's true that doctors can in their discretion prescribe drugs for off-label uses, drug companies are strictly prohibited under federal law for off-label marketing. And while Teva pled guilty and paid a fine for off-label promotion, they made substantially more than that in revenue from Actiq and Fentora.

The evidence will show that even as late as 2017, Teva continued to teach that opioid phobia leads to undertreatment of pain and that, in general, patients do not become addicted to opioids; thus, continuing to downplay the very real risks of opioids.

While always pressuring sales reps to maximize sales, incentive compensation targets, quotas, bonuses, the goals provided the sales rep -- to the sales reps at the national sales meeting, quote, "Money. Money. Money." Again, their

livelihood based on how much they sell and yet they are the ones tasked with educating doctors about the risks of opioids; and with addressing SOMS concerns, it's an unfair practice where controlled substances are concerned, and it contributed greatly to the nuisance.

A quick two-minute video, Your Honor, created by Teva for a sales training perhaps intended to be funny, but the messaging is very, very clear. And, remember, fentanyl was only approved for breakthrough cancer pain.

(Video was played but not reported.)

MS. BAIG: Another video, Your Honor, played by Teva for sales reps that follows from the first. And just so you can follow the thread, here Mr. Spokane, the sales rep who didn't get coffee in the first video because he didn't sell enough, was caught using an unapproved, unauthorized homemade sales aid to sell more. And the question here is whether his sales director told him to do it or not, and a trial ensues.

(Video was played but not reported.)

MS. BAIG: Again, Your Honor, Teva will likely tell you that this is just intended to be funny, and it might have been funny if they were talking about less dangerous products; but we're talking about fentanyl here, far more powerful than morphine, which was only approved for cancer patients.

And what is message from the sales director to the sales reps here? It's that we live in a world where sales reps have

to meet and exceed quota.

THE COURT: Let's take a recess now. We'll be in recess until 11:00 o'clock.

MS. BAIG: Okay.

THE COURT: Thank you.

(Recess taken at 10:46 a.m.)

(Proceedings resumed at 11:00 a.m.)

THE CLERK: Come to order. Court is now in session. You may be seated.

THE COURT: Okay. You may continue.

MS. BAIG: Thank you, Your Honor.

And one last sales video for now, Your Honor, which comments on the Teva-funded, quote/unquote, "studies" the company could create to show all doctors in every location, not just cancer doctors, how great fentanyl was for all breakthrough pain, not just cancer pain.

(Video was played but not reported.)

MS. BAIG: You will hear form our marketing expert, Berkeley Professor Jeziorski, that collectively defendants brought over 2 million marketing impressions into San Francisco.

You will hear from our marketing expert, Matthew Perri, that defendants' marketing conduct clearly violated industry standards and that it contributed to the growth and expansion of the opioid market.

Okay. Apart from the marketing, the manufacturers also engaged in unfair business practices related to their suspicious order monitoring system, SOMS. These unfair business practices also worked to fuel the public nuisance.

As we've discussed, defendants had obligations to identify, halt, and report to the DEA suspicious orders under the Controlled Substances Act.

You've seen these elements of the Controlled Substances Act before. I won't go through them again, except to add that it's been recognized by Congress that diversion of opioids into illicit channels is dangerous to individuals and to the community at large.

In enacting the CSA, Congress stated that diversion and illicit use of controlled substances have a substantial and detrimental effect on the health and general welfare of the American people.

Congress further recognized that diversion of controlled substances presents a danger to the safety of the community.

In 2007, the DEA through Joe Rannazzisi reminded manufacturers of their obligations under the CSA stating that (as read):

> "Registrants must conduct an independent analysis before completing a sale to determine if opioids are likely to be diverted and that reliance on rigid formulas to identify suspicious orders is not enough."

The DEA said in its 2000 letter to manufacturers that (as read):

"Even just one distributor that uses its DEA registration to facilitate diversion can cause enormous harm."

In a follow-up 2012 letter, the DEA told manufacturers and distributors that their role in the proper handling of controlled substances is critical for public safety as it helps to protect society against drug abuse and diversion. Nevertheless, the Watson-Actavis-Allergan entities had no meaningful SOM system from 2000 forward.

Nancy Baran, who was head of SOMS at Actavis noted that with their existing SOM system in 2009, if a customer's monthly usage limit was 3,000 units, that customer could order 2,999 units every day of the month and it still would not be caught.

She also noted that orders were coming in all day long over the 25 percent threshold, 25 percent over the historical average for a given customer, and that their suspicious order report did a, quote, "lousy" job.

And in all the orders that Actavis shipped, how many were reported to the DEA?

(Video was played but not reported.)

MS. BAIG: In 2012, the DEA called Actavis to its headquarters to address significant concerns regarding diversion of opioids. At the meeting, the DEA reminded Actavis

that it was responsible for ensuring that oxycodone is not diverted.

The DEA told Actavis that manufacturers are just as responsible as distributors and pharmacies for preventing diversion, and urged Actavis to be part of the solution and not the problem.

The DEA asked them to get to know their customers' customers for Actavis products. Notably, Actavis already knew their customers' top customers. As we saw earlier, they purchased that data for marketing purposes and they also had access to chargeback data from their distributor customers.

So Actavis was already very well aware of who the top downstream customers were, but the evidence will show they only used that information for marketing purposes, not for SOMS.

The DEA also raised the issue of quota with Actavis. Specifically, Actavis compliance officer Michael Clarke was at the DEA meeting, and he had a very vivid memory of it. He testified that the DEA treated them like street dealers. He also testified about Actavis' response to the DEA's request that they reduce quota to protect against diversion against oxycodone.

(Video was played but not reported.)

MS. BAIG: CEO Doug Boothe confirmed Clarke's testimony that he wasn't interested in reducing quota. Astonishingly, he also testified that he did not believe that

Actavis had any obligation to prevent diversion.

The evidence will show that in 2012, Actavis worked to revise its SOM system. It installed the revised system, which required it to monitor its downstream customers and report any problems not only to the distributors but also to the DEA, but it abandoned that new system in less than three months as a result of merger activity and reverted back to the old system.

The Watson SOM system wasn't better than Actavis's. From 2000 to 2016 it made four reports to the DEA in total and none were in writing. The Watson team was run by sales and marketing, a team again that's compensated based on their ability to maximize sales. So tasking that team with halting suspicious orders creates an inherent conflict of interest.

This evidence will come in through Mary Woods, who worked as part of the customers relations team which oversaw DEA compliance.

Tom Napoli, the head of Watson DEA Affairs Group, hired Cegedim, a/k/a Buzzeo, to do an audit. The auditor failed Watson system and told Watson it would have to revisit their entire approach to fully address the DEA SOMS requirements.

Like the Watson-Actavis-Allergan entities, the Teva SOM system was similarly deficient. Sales reps were the first line of defense regarding SOMS issues. Out of millions of orders, they identified zero suspicious orders prior to the end of 2012 and they identified only 28 from 2013 to 2018.

Colleen McGinn, who was in charge of SOMS at Teva, admitted that Teva did not have adequate resources for its SOMS program and testified that an audit revealed Teva SOM system to be at high and moderate risk for DEA action.

The same outside auditor Cegedim, a/k/a Buzzeo, that reviewed the prior systems reviewed Teva's as well in 2012, and found that Teva had a rudimentary SOM system that had never identified or reported a single suspicious order.

The auditor further found fault with Teva's failure to review its downstream distribution; i.e., its customers' customers, like pharmacies. And, yet, the evidence will show that like Allergan, Teva too had access to prescriber and pharmacy-level today data and used it for marketing but not SOMS purposes.

Here we have Teva's diversion operations manager, Mr. Tomkiewicz, shedding light on the nature of the problem, the inherent tension of having sales employees paid with incentive compensation play a substantial role in suspicious order monitoring.

(Video was played but not reported.)

MS. BAIG: Notably, the former director of DEA compliance at Teva doesn't deny any responsibility for fueling the opioid epidemic. In fact, she accepts it.

(Video was played but not reported.)

MS. BAIG: In 2012, Tomkiewicz circulated an e-mail

entitled "OxyContin for Kids" with a graphic of the kids Kellogg's Sugar Smacks serial box, except that it said "Kellogg's Smack" and had the frog injecting himself with a syringe.

I'm all for comic relief, but this is the corporate investigator in 2012 when the nation and San Francisco were already in the midst of a devastating epidemic.

And this, Your Honor, is -- he circulated this e-mail in 2012 when he worked for AmerisourceBergen. He was subsequently hired to run SOMS for Teva.

Tomkiewicz also circulated a song called "Beverly Pillbillies" laughing at the crisis, mocking at it, referring to them as a bevy of pillbillies traveling south to Florida cash-and-carry pill mills all to the tune of the *Beverly Hillbilly* theme song.

And they would have us believe that Teva was striving to comply with the CSA requirements, that they took the obligation seriously when the corporate investigator that they hired had circulated things like these.

Finally, with regard to Teva SOMS, Teva did, like Allergan, come up with a replacement for its SOMS program, but in 2015 that program too was found to be deficient. An internal audit report noted that in the past year, only two suspicious orders had been reported to the DEA.

Turning now to Anda. Anda was founded in 1992. As of

2006, it was owned by Watson, which became Actavis, which became Allergan Finance LLC, and it distributed the majority of Allergan's opioids and then Teva's when it was sold to Teva in 2016. It was also a primary supplier of internet pharmacies.

In 2011, the DEA sent a letter to Anda vice president Albert Paonessa stating the results of their investigation of Anda the year prior. The DEA stated that Anda failed to maintain complete and accurate records of controlled substances and further called out Anda's pattern of distributing larger quantities of controlled substances than permitted.

The DEA noted that Anda had a monthly limit of 5,000 dosage units for certain customers yet shipped many more units to those same customers. The letter concluded that (as read):

> "This letter is formal notification that your firm is in violation of the CSA."

An internal e-mail from 2012 confirms that Anda had reported zero suspicious orders in the last five years.

In 2015, Buzzeo did an audit of Anda's SOM system and made many recommendations to bring Anda's system into compliance, including that Anda needed a "know your customer" program.

The DEA also called Anda out for using eight as the multiplier to trigger orders of interest as part of its SOMS program. That means a customer could order up to eight times its historical average before an order would even be flagged as of interest.

An internal e-mail also shows that Anda agreed to use marketing to push hydrocodone, Oxycontin, and fentanyl, and it did precisely that.

Despite the fact that Anda is a distributor and not a manufacturer, it did actively and aggressively market opioids by encouraging pharmacies to send fliers to customers which, for example, offered discounts to customers who had not purchased controlled substances from Anda in the past 12 months.

Former DEA Investigator James Rafalski has reviewed all of the SOMS programs at issue here, compared them with industry standards, and found that defendants failed to design and operate adequate suspicious order monitoring systems and failed to maintain effective controls to prevent diversion.

The conduct of Allergan, Teva, and Anda, all of this marketing, all of these SOMS failures, has had a tremendous effect on the country and on San Francisco.

The People's epidemiologist Katherine Keyes will testify that with increased supply came increased heroin and fentanyl deaths, and that 75 percent of people addicted to illicit opioids began with prescription opioids.

The People's expert Daniel Ciccarone, professor of Family Community Medicine at UCSF, will testify there is a well-defined link between the use of prescription opioids and the subsequent use of illicit opioids.

Heroin overdose deaths have increased 394 percent nationally from 2008 to 2018. Opioid overdose deaths have increased 178 percent.

Your Honor, with that, I would like to turn the discussion back over to my colleague for a discussion of Walgreens.

THE COURT: Thank you.

(Pause in proceedings.)

MR. HEIMANN: I'm pleased to report we're actually going much quicker than I expected, frankly.

THE COURT: Okay.

OPENING STATEMENT

MR. HEIMANN: So the case against Walgreens -- thank you.

The case against Walgreens comes down to three primary elements: Collaboration, distribution, and dispensing.

I'll start with the collaboration case, and let me begin by noting that the case against Walgreens covers a period of more than actually 20 years, and much of the proof in the case is drawn from the business records of the company itself; and so I'm forced to refer to a fair number of exhibits in the course of presenting the basis for the claims against Walgreens. So I'm hoping Your Honor will bear with me with respect to that.

So with respect to collaboration, it wasn't just the manufacturers who promoted the new opioid message. Walgreens

collaborated with the manufacturers, including Purdue and others, in the promotion of opioids promoting them to pharmacists, to doctors, and even to patients.

That collaboration between Walgreens and Purdue began as early as the introduction of OxyContin in the 1990s. Walgreens engaged in multiple means to promote the widespread availability of access to opioids at Walgreens pharmacies.

One of the Walgreens ideas included the notion of superstores, stores that would be open 24 hours a day and would stock narcotics multifold beyond what they actually expected would be needed in the areas covered by the superstores.

They intended to inform high-prescribing opioid doctors in the area of the stores that they could always be counted on for an adequate inventory of opioid drugs.

In addition, the notion was promoted that the stores would allow Schedule II prescriptions to be telephoned into the pharmacy by the doctor rather than requiring that it be presented in the first instance by written script.

On Purdue's part, it proposed to assist Walgreens in the opioid business by actively promoting Walgreens as the pharmacy for prescribers and patients to patronize.

And in this instance I'm showing you a Purdue e-mail exchange, internal, in which a level district manager at Purdue is talking to a salesperson at Purdue about communications that that salesperson had had with a Walgreens pharmacist.

And the district Purdue manager is advising the salesperson that he could inform the Walgreens pharmacist that he was dealing with, that if he can keep adequate inventory of all sizes of OxyContin available in the store, that you can then inform you -- the salesperson can inform our key accounts, meaning physicians primarily, including telling the doctors which are the preferred pain stores in the area.

And that Purdue employee went on to say (as read):

"While we're not in the business of promoting pharmacies per se, it is obligation to our customers" -- again, meaning doctors that they were detailing -- "to direct them to locations that will without a doubt be carrying our OxyContin line. You should inform these key doctors, nurses, physician assistants, and nurse practitioners, et cetera, on your calls and have a list available near their phones so they can take action towards OxyContin prescriptions at a moment's notice."

According to Purdue, this particular pharmacist they were dealing with advertised -- actively advertised to doctors and patients in his area that Walgreens was a full-service pain management pharmacy. Even going so far as saying (as read):

"The doctors will have the assurance that the pain meds will be filled by a pharmacist less likely to question his or her prescribing habits."

According to Purdue, this pharmacist actively advertised

that, among other things, they would be -- Walgreens would be accepting after-hours emergency Schedule II prescriptions without a hassle.

In addition to this sort of collaboration between Walgreens and Purdue and other manufacturers, Walgreens actively sought out KOLs, key opinion leaders, and continuing education courses for, among others, its own pharmacists.

Walgreens sought out speakers from Purdue's speaker program with key opinion leaders to educate Walgreens' pharmacists on opioid and pain management through continuing education courses, and assured Purdue that the programs would be distributed to Walgreens' pharmacists nationwide, and also to recognize Purdue's sponsorship of the programs on Walgreens website where pharmacists submit the forms for continuing education credit.

Purdue was eager to comply and even agreed to fund the continuing education programs for Walgreens because, as Purdue's head of sales and marketing said in the year 2000 (as read):

> "The last thing we want is for the OxyContin prescription to be bounced out at the pharmacy level because of uneducated fears from," quote, "the 'uneducated'" -- "unfounded fears" -- excuse me -- "from the," quote, "'uneducated pharmacist."

The continuing education lectures and the programs that

they used invariably misrepresented critical aspects of opioids and pain management.

For example, the program entitled "The Use of Opioids in Chronic Noncancer Pain" by a gentleman by the name of Lipman, whose name will come up again in a few minutes, instructed Walgreens pharmacists that (as read):

"Addiction from prescription opioids was rare.

"Opioid -- excuse me -- "Iatrogenic" -- that's a hard word to pronounce, but I understand -- I've learned that that means doctor caused basically by treatment -- "Iatrogenic addiction from opioid analgesia in patients experiencing pain is exquisitely rare."

And also the promotion and the continuing education material made reference to (as read):

"Addiction" -- "Addicts normally exhibit profound drug-seeking behavior, but drug-seeking behavior is not necessarily indicative of abuse. Such patients have been described in the oncology setting as pseudoaddicts. Pseudoaddiction is appropriate drug-seeking behavior for the purpose of comfort not abuse."

Walgreens sought hundreds of copies of these materials to distribute to its pharmacists.

Why? Because corporate Walgreens was concerned that the pharmacists, or at least a good many of them, were skeptical at that time about the appropriateness of the use of opioids for

chronic long-term purposes.

Purdue was also justly concerned that in the early period of OxyContin sales some pharmacists were skeptical of the use of opioids for chronic pain.

As the head of Purdue's sales and marketing wrote at the time (as read):

"There is so much misinformation at the retail pharmacist level, and the last thing we need is a retail pharmacist refusing to fill or questioning a prescription that one of your reps worked so hard to generate. The issues at the retail level always seem to come back to unfounded fears of regulation and lack of knowledge of pain management terminology, such as physical dependence, addiction, abuse, diversion, et cetera."

Purdue saw the continuing education programs as a way for Purdue to forge a stronger alliance with Walgreens and at the same time deal with Walgreens' pharmacists who were concerned about opioid abuse.

Here is another internal Purdue e-mail exchange (as read):

"I spoke with Walgreens' district manager. He was very pleased to hear that" -- "very pleased to hear that we have a pain CE" -- meaning continuing education -- "and he wants 150 of them so that he can mail them to all the pharmacists in his district."

"This will help us gain a stronger alliance with

Walgreens and help to fend off any remaining abuse issues that are going through their stores."

Walgreens itself was quick to take action with pharmacists who expressed concerns about opioid prescribing.

When one of Purdue's speakers reported back that some of Walgreens' pharmacists who had attended a continuing education program that he had presented were questioning doctors who were prescribing OxyContin, Purdue contacted the Walgreens district managers who promptly agreed to deal with the matter in this way (as read):

"The district" -- this is the Purdue reporting what they had learned from the district managers. "The district managers will send an e-mail to all stores" -- meaning all Walgreens stores -- "reinforcing expectations."

Walgreens employees were keenly aware -- excuse me.

The continuing education programs were effective in boosting sales of OxyContin and sales by Walgreens as Purdue's analysis itself confirmed.

In March 2001, Purdue measured the impact on sales of continuing education presentations in five rural towns in Utah, and found that after Mr. Lipman or Dr. Lipman had presented several continuing education programs in that area, this was the result (as read):

"Interesting to note that range of OxyContin sales

increases was anywhere from double to eight times that of the average prior to the lectures. This is outstanding."

Walgreens business employees were keenly aware of the impact of sales of OxyContin and other products and profitability and the importance of continuing education programs for persuading the pharmacists to fill prescriptions.

As one Walgreens district manager told a Purdue representative (as read):

"He informed me that a few pharmacists were afraid to stock and dispense OxyContin because of theft. He also informed me that OxyContin is one of the most highly profitable items to dispense and did not want to miss out on any sales because of fear of theft or suspicion of diversion. He would like to personally educate and mandate completion of continuing education programs by Lipman on the use of -- excuse me -- on the use of opioids in chronic pain at his biweekly meeting. He supervises 30 pharmacists in his territory."

And, incidentally, the district manager they're talking about here is a gentleman by the name of Richard Ashworth who later became the president of Walgreens.

In order to make the Purdue-sponsored continuing education programs more effective, Walgreens proposed that they be presented on a regional basis.

And this is a Purdue internal e-mail again reporting on

the conversations they had had with Walgreens about that (as read):

"For the first time ever Walgreens has agreed to a regional approach. Why was that important? Because we can hit a lot more pharmacists this way."

Purdue saw this as a great opportunity to address the concerns they knew Walgreens pharmacists had with opioid dispensing.

Another Purdue e-mail acknowledging (as read):

"We are hearing many concerns at the retail level."

Meaning concerns from pharmacists or about pharmacists.

"This would be a great educational opportunity to help preserve the rights of the pain patients while helping to further educate the Walgreens pharmacists."

Walgreens management of trade relations, a woman by the name of Dawn DiLullo, thought that presenting testimonials from high-dose opioid patients was a great way to get pharmacists past their concerns.

Again, a Purdue e-mail reporting conversations with this lady (as read):

"She suggested patient testimonials at these programs to help the pharmacist in understanding the need for high dosage levels given appropriately to meet people in need."

When Walgreens suggested that Purdue finance a continuing education program which addressed human factors in pharmacy

errors, Purdue agreed and agreed to pay for it but only if they could have one of their programs on pain management at the same time.

This is, again, reflected in an internal Purdue document (as read):

> "I explained to Dawn that we could only support this with a small contribution if we could have one of our programs on pain management with this. Dawn was in complete agreement. Walgreens was happy to oblige and even asked for a disk, an electronic disk, of the pain management program so they could" -- so that it could be put up on Walgreens pharmacy website and available to all Walgreens pharmacists nationwide."

It wasn't just Purdue that Walgreens cooperated -- collaborated with. They held other manufacturers to sell opioids as well.

For example, when Endo brought Opana to market, they looked to Walgreens to help launch their new product and Walgreens eagerly complied.

Here's an e-mail internal to Endo in which they were reporting what they had accomplished with Walgreens (as read):

> "I feel confident that our sales team will do the job and pull this product off your shelves." I'm sorry. This is an e-mail from Endo to Walgreens. "We need Walgreens to make the launch of Opana a success."

Walgreens also collaborated with Endo to spread misinformation about opioids and increase dispensing of opioid products.

And this collaboration included continuing education courses that emphasized the importance of the pharmacist as a source of information for both laypersons and healthcare professionals, and at the same time emphasized pro-opioid messages such as the notion that opioid phobia was a source of irrational fear and prejudice (as read):

> "Pharmacists are the primary drug information resource for laypersons and healthcare professionals. Patients and physicians alike" -- this is from the continuing education piece that they were using at the time -- "Patients and physicians alike have various fears and prejudices associated with the use of opioid analgesics, which seems to unnecessarily limit the use of this class of medicines. The term 'opioid phobia' has been coined to refer to these fears, which may be a result at least in part of misunderstandings concerning the concepts of addiction, physical dependence, and tolerance."

So in sum, Walgreens was actively involved in the promotion of opioids itself, not only to its own pharmacists to overcome concerns that its own pharmacists had about the use of opioids for chronic pain and for long-term periods but also to

patients and to doctors as well.

As our expert Anna Lembke will testify, she will explain the Walgreens collaboration in greater detail than I have here today with drug manufacturers and the consequences of that collaboration.

I mentioned there were three primary bases for the liability case against Walgreens. The second has to do with distribution and what you've heard about already, the whole subject of suspicious order monitoring.

Walgreens had three distribution centers that distributed Schedule II controlled drugs. One was in Perrysburg, Ohio, served the northwest for the most part -- northeast, excuse me, for the most part; second in Jupiter, Florida, where my mother lives, by the way; and then, finally, the third was in Woodland, California, near Sacramento.

From as far back as the 1980s to at least 2012, Walgreens had no system which satisfied its legal obligations to identify and investigate suspicious orders.

The system they did have, if it could be called a system, involved, one, no due diligence or investigation of suspicious orders; two, no reporting to the DEA upon discovery of suspicious orders, and orders were shipped routinely despite knowledge on the part of Walgreens as a distributor of their suspicious nature.

To the extent they had any sort of program to identify

suspicious orders, this is how they described it to DEA investigators in about 2006 I believe this is from, and this is reflected in an internal Walgreens memorandum (as read):

"The explanation of the formula is all stores are put into groups of 25 based on the amount of daily prescriptions filled. The average from these stores is then taken from the orders to the DC" -- that is distribution center -- "on each group of 25" -- so they are putting 25 stores together, take an average on a monthly basis of what the size of their orders is -- "and then the trigger is equal to the average order times the DEA factor."

And what was the DEA factor? Three. So what that means is that unless an order from a pharmacy to the district -- the distribution center exceeded by three times the average orders for that store and its group of stores, it was not deemed suspicious. It passed through undeterred.

After the visit on that occasion from the DEA to the -- it was the Perrysburg center incidentally, Walgreens wrote internally (as read):

"After that inspection, the DEA specifically informed" --

I'm sorry. Let me back up. This is what the Walgreens memorandum that I was referring to reported internally about what the DEA had orally advised the representatives of

Walgreens at the distribution center (as read):

"The DEA feels that the suspicious order report is inadequate. They specifically did not like the DEA factor and would like to know how we determine it. They said the formula should be based on size, pattern, and frequency."

And I'll note that there are records within Walgreens that show that Walgreens was fully aware of the size, pattern, and frequency formula way back in the 1990s, if not before, and note that the actual formula they were using at the time involved only size. That's three times the prior order.

It had no formula for identifying suspicious patterns or for identifying frequency as a basis for concern or suspicion with respect to an order.

For at least as early as 2006, the DEA repeatedly informed Walgreens that it was not in compliance with its legal obligations under the Controlled Substances Act and the applications under that, but to no avail.

After a visit from the DEA to the Perrysburg center, Walgreens wrote as I've indicated.

After that inspection, the DEA specifically informed Walgreens in writing that the suspicious order -- excuse me -- the suspicious ordering of controlled substances program in use at Walgreens was not in compliance with the statute and regulations.

And this is an excerpt from that letter written in,

I believe, May of 2006 with respect to the investigation and visit that had occurred two or three months earlier (as read):

"The formulation utilized by the firm for reporting suspicious ordering of controlled substances was insufficient."

And the DEA went on to quote for Walgreens the requirements of the regulation, that requires the registrant design and operate a system to disclose to the registrant suspicious orders of controlled substances and inform the DEA of suspicious orders.

Now, Your Honor, I think I'm at the point where I need to -- well, is this one all right? I don't want to get afoul of what we've agreed to here. Slide 58?

MS. SWIFT: I'm sorry, sir. I don't know what agreement you're speaking about.

MR. HEIMANN: Our collective agreement not to display --

THE COURT: Why don't you go over and talk to her?

MR. HEIMANN: Yeah.

(Pause in proceedings.)

MR. HEIMANN: Thank you, Your Honor.

All right. I think at this point, Your Honor, I have to hand up the slides that we're going to be talking about.

THE COURT: Okay. Just give it to Ms. Scott, but identify it as a number. Is there a number to it?

Okay. So I'm being handed Plaintiffs' Exhibit 20656, and now I'll read it. I assume that's why you're giving it to me.

(Pause in proceedings.)

MR. HEIMANN: So I should have a blank here. Yeah, all right.

So I was saying, the internal audit function, if you will, Your Honor, at Walgreens repeatedly informed corporate that the company was in violation of its obligations and was systematically filling suspicious orders that could lead to diversion of controlled drugs.

Now, when I say "the internal audit function," I mean that arm within Walgreens company that was responsible for reviewing -- and for purposes of compliance -- the conduct of the company.

And with respect to the suspicious order monitoring obligation and responsibility, that internal audit function repeatedly informed corporate Walgreens in Chicago that they were not in compliance with the regulations.

MS. SWIFT: Your Honor, I apologize truly for interrupting. I understand that the document is on the screen for all to see.

THE COURT: Oh. Why is it on the screen?

MR. HEIMANN: I didn't think that it was. This is Number -- you said Number 79, and the only one that's on the screen is 78.

MS. SWIFT: My apologies. It's the same. It's the same document.

THE COURT: Well, we'll take it off the screen.

(Pause in proceedings.)

THE COURT: Thank you.

MR. HEIMANN: All right. Sorry, Your Honor.

THE COURT: No. But, I mean, I want it clear, it is the parties' responsibility for what goes on the screen. So just be mindful of that responsibility.

MR. HEIMANN: Yes, Your Honor.

THE COURT: Thank you.

MR. HEIMANN: The internal audit function in this incidence reported that (as read):

"Walgreens is submitting this monthly suspicious control drug orders report to the DEA with numerous instances of filled suspicious controlled substance orders. Also, there is no monitoring process in place to stop a suspicious order to assess if the order is suspicious or not."

MS. SWIFT: Your Honor, once again, my apologies.

THE COURT: You don't have to apologize. What is the --

MS. SWIFT: He's reading from the document.

THE COURT: Yeah. I wondered about that.

I don't think you can read it. The point is that --

there's an argument that this is privilege, this is a privileged document.

So I'll read it. I can read it. Obviously I'd have to make that -- I'd have to read it to make a determination.

So I'm going to strike your reading of it from the record, and I'll read it as I have. So I think we can move onto the next document that you want me to read, and I'll read it, but do not show it.

Is it -- the next document is also purportedly privilege or not?

MS. SWIFT: It's slides 78 through 86, which are different excerpts, I believe, all from the same document.

THE COURT: Okay. So --

MR. HEIMANN: No. That's not correct, Your Honor. May I?

THE COURT: Well, anyway, be guided by the fact that if it's --

MS. SWIFT: It is those slides.

THE COURT: If Walgreens' counsel has identified them, don't -- you can point me to them. I'll read them myself, but don't recite them into the record.

MS. SWIFT: Thank you, Your Honor.

THE COURT: I'll mark this for the record so that it's clear in any reviewing court what I have seen and what I haven't seen. Is that satisfactory?

MS. SWIFT: Yes. Thank you, Your Honor.

THE COURT: Okay. All right.

MR. HEIMANN: So the exhibits in question, if I may, Your Honor, Exhibit 20656 --

THE COURT: Okay. And I've read that.

MR. HEIMANN: -- and 20658 --

THE COURT: Okay. Let me read it right now to myself.

(Pause in proceedings.)

THE COURT: I've read that.

MR. HEIMANN: There are three excerpts from that exhibit.

THE COURT: Okay. I'm on the page 81 of that.

(Pause in proceedings.)

THE COURT: Now I'm on page 82 of it.

MR. HEIMANN: Yes, Your Honor.

(Pause in proceedings.)

THE COURT: Okay. Thank you.

MR. HEIMANN: And then Exhibit 57.

THE COURT: 57? I'll read that to myself.

(Pause in proceedings.)

THE COURT: And now I'll read page 84. It's Plaintiffs' Exhibit 57.

MR. HEIMANN: Yes, Your Honor.

(Pause in proceedings.)

THE COURT: Page 85. This is now Plaintiffs' Exhibit

19904, is that also --

MR. HEIMANN: Yes, Your Honor.

UNIDENTIFIED SPEAKER: [Inaudible.]

COURT REPORTER: I'm sorry --

THE COURT: You have to -- first of all, anybody who speaks has to identify who they are, not like "Voice Heard From Body of Courtroom."

So if you want to speak, you have to be in front of a microphone and you have to identify yourself, and I don't know who you are.

MR. BUDNER: Apologies, Your Honor.

THE COURT: That's okay.

MR. BUDNER: Kevin Budner from Lieff Cabraser on behalf --

THE COURT: From where?

MR. BUDNER: -- on behalf of the People.

I only wanted to clarify that Your Honor is viewing the slide -- what we've been calling the exhibit numbers are the slides from the deck and the actual underlying exhibit is in Tab 4 of your binder, if you'd like to review it, the underlying exhibit itself.

THE COURT: The underlying exhibit is, sorry, what?

MR. HEIMANN: What he's saying is the full exhibit is in your binder. These are just excerpts from that exhibit.

THE COURT: Oh. Okay. I appreciate that. Thank you.

Thank you for that clarification.

So when I refer to Plaintiffs' Exhibit 19904, the full exhibit would be in the binder?

MR. HEIMANN: Yes.

THE COURT: And this is page 85 of that full exhibit, I guess.

MR. HEIMANN: Yes.

THE COURT: I mean, it has 85 on it. Or is it some other page?

MR. BUDNER: Your Honor, my apologies again. Kevin Budner for the People.

The page number 85 just refers to the slide number in the deck. It's not a page number of the exhibit.

THE COURT: Okay. It's a slide number in the deck. Okay. I'll read it in any event. Okay.

(Pause in proceedings.)

THE COURT: And Slide Number 86, okay.

(Pause in proceedings.)

THE COURT: Now, I do have a question about the document itself, which is who prepared this? As I understand it -- and you can chime in, Counsel -- as I understand it, this document was prepared as a -- from the internal audit division, if we can call it that -- I don't know what to call it, section -- of Walgreens to be presented to a higher management or management of Walgreens.

MS. SWIFT: Correct, in addition to counsel, Your Honor.

MR. HEIMANN: Well --

THE COURT: In addition -- in other words, it was prepared for both of those entities?

MS. SWIFT: That's correct, Your Honor.

THE COURT: Okay. And I will entertain some discussion about that when we get to it. You've objected to it on privilege grounds.

Have you addressed it in a -- in a brief or not?

MS. SWIFT: Not before Your Honor, no. We've addressed it in front of Judge Polster.

THE COURT: Okay. Okay.

MS. SWIFT: It hasn't come up until just now in front of you.

THE COURT: All right. Okay. But before Judge Polster was it briefed or was it not briefed?

MS. SWIFT: It was briefed, Your Honor.

THE COURT: Okay. All right. Thank you.

We'll move on. I now have read this, but we don't want to show it. Okay.

(Pause in proceedings.)

THE COURT: Go right ahead, Mr. Heimann.

MR. HEIMANN: Yes, Your Honor. I want to make sure I don't --

THE COURT: Right. I appreciate that.

MR. HEIMANN: I'm trying to get my slides correct so I don't put up the wrong -- let me do this, Your Honor.

I think it's important for me to summarize what Walgreens was actually doing with respect to suspicious order monitoring program.

What they actually did was this: They had this three times trigger we were talking about. And as it turns out, over many years that times trigger actually identified -- hit a great many times.

Despite the fact that it was hitting on orders, the orders were not investigated in any way, shape, or form and instead were simply shipped.

And then at the end of the month, or sometimes on a quarterly basis, the distribution centers would send to the DEA -- the appropriate office of the DEA a massive list of all of the orders that had hit as suspicious but had been shipped anyway without any sort of investigation or review to determine whether it was appropriate to ship those orders. In fact, witnesses have described the size of those reports as phone book size.

So what the point here is, Walgreens was actually identifying, according to their substandard at best system, based only on size multiple orders that were suspicious but shipping them and conducting no due diligence and not informing

the DEA of those shipments until after the fact, all clearly in violation of what they had to have known their obligations were because they were told repeatedly by the DEA what their obligations were.

And all they had to do to know what their obligations were was to read the federal regulation.

THE COURT: Okay.

MR. HEIMANN: And all of that was acknowledged multiple times by internal audit and communicating to management.

Now, I need to get to Slide 87, please. Thank you.

All right. So we've been talking about internal audit reports in the year 2007-2008.

Almost two years later in an internal e-mail circulated widely to corporate Walgreens, Walgreens divisional VP of supply chain wrote concerning the still unchanged suspicious order monitoring system, and this is what he wrote at the time (as read):

"I recall the old paper report as being inches thick" -- he's talking about that monthly report that I just described -- "inches thick full of suspicious orders that they had filled."

He goes on to say (as read):

"We were instructed in 1985 not to review or contact anyone on the data."

And then he poses this question (as read):

"Who from your group has been reviewing the data collected for the past 25 years?"

THE COURT: Sorry. This document was sent to whom?

MR. HEIMANN: I'd have to blow it up. It's an e-mail and you can see the recipients of the e-mail. There are probably a dozen or more.

THE COURT: Well, can you categorize the position of the person who received the e-mail?

MR. HEIMANN: My understanding is that they were employees of Walgreens mostly, if not all, headquartered at their corporate headquarters in Chicago.

THE COURT: Okay.

MR. HEIMANN: I could be wrong about that.

THE COURT: Well, we'll see. I mean, that's what the trial is about in part.

MR. HEIMANN: And, by the way, we couldn't find an answer as to who has been reviewing the data for the past 25 years.

I don't think it was a rhetorical question; but, in any event, I don't believe the author of this question got an answer.

Moving on, if I may, Your Honor. In September 2012 -- so now we've moved on a few years later -- the DEA issued an order to show cause and immediate suspension -- I didn't know when

Your Honor wanted to stop for lunch so --

THE COURT: No, no, no. I want to go to 12:15 if we can.

MR. HEIMANN: Very well.

In September 2012, the DEA issued an order to show cause and immediate suspension of registration. That's important.

Immediate suspension of registration means the DEA has decided that the situation is so critical that it is imperative to stop, in this case, the distribution from this Jupiter facility immediately. Not to simply bring a charge and subsequently litigate it but, rather, to stop the distribution in its tracks.

And that was with respect to the Jupiter, Florida, distribution center and also involved similar action with respect to a number of pharmacies located -- Walgreens pharmacies located in Florida alleging gross violations of Walgreens duties and responsibilities with respect to suspicious order monitoring.

In December of 2012, Walgreens' head of a newly created group called Pharmaceutical Integrity -- Pharmaceutical Integrity was a group that was created in late 2012, early 2013 directly as a consequence of DEA action being taken against Walgreens having to do both with their distribution failures and their dispensing failures that were resulting in diversion of narcotic drugs. And you'll hear more about them, a little

bit more from me today and a great deal more during the course of the evidence at trial.

In December of 2012, the Walgreens head of the newly created then Pharmaceutical Integrity Group wrote that the DEA was seeking actions against their registrations.

And that's exactly what they were, registrations, particularly of the Jupiter facility, meaning the Jupiter facility as a DEA registrant. And what the DEA was proposing to do to was pull that registration, which would mean the DC, distribution center, would be out of business altogether.

And she said in the e-mail that the head of Pharmaceutical Integrity wrote at that time, that they were demanding -- "they," the DEA was demanding civil penalties totaling hundreds of millions of dollars.

She also acknowledged in that e-mail that the DEA had confirmed orally that additional regulatory actions were pending against other Walgreens distribution centers -- there were only two others. One is in Woodland and the other in Perrysburg, Ohio -- regarding Walgreens' failure to comply with federal law with respect to distribution.

And then she added this (as read):

> "In response, the company has enhanced its suspicious order monitoring program for controlled substances in an effort to convince DEA that the proposed penalty is excessive."

But, in fact, the DEA continued its investigation of Walgreens' distribution practices. In February of 2013, the DEA subpoenaed records from the Perrysburg distribution center -- so now they've closed the Florida center and now they're moving on to Perrysburg -- looking for suspicious orders dating back from February 2011. I'm paraphrasing from an e-mail, internal e-mail, at Walgreens that reported this.

Walgreens' personnel at Perrysburg, who were obviously familiar with the ordering and fulfilling practices at Perrysburg at the time, believed in response to that subpoena that it was only a matter of a short period of time before they got closed down.

This is an e-mail internal (as read):

"In response, the company" -- "Last week the DEA came into Perrysburg with subpoenas looking at records for suspicious drug ordering dating back to February 2011. We believe they could lock Perrysburg up and not allow us to ship from there."

They were right. They went on to say (as read):

"With respect to" -- This is CII. That's a reference to Schedule II narcotics -- "Perrysburg will continue to pick" -- that's the term that was used meaning pick, pull drugs from the shelves and send them off to their Walgreens stores -- "what they can until the DEA comes and shuts them down."

In 2013, Walgreens entered into a settlement with the DEA in which it admitted violations relating to distributing controlled substances.

And here's just a portion of the memorandum of agreement that was entered into at that time (as read):

> "Acknowledges that suspicious order reporting for distribution to certain pharmacies did not meet the standards identified by DEA."

And you'll remember those three letters that we talked about earlier. This is with reference to the Jupiter DC specifically, but obviously it had greater implications, given the same practices that were followed in Jupiter were followed in Perrysburg and in the Sacramento facility, Woodland facility.

In addition, Walgreens agreed to pay a world record fine at the time of $80 million. I may be overstating world record, but an enormous fine at the time of $80 million.

At about that same time, Walgreens corporate came to the realization that they weren't going to be able -- I'm inferring this now -- to really operate distribution centers that would be operated in compliance with the law, and so they made a decision to get out of the business of distributing Schedule II drugs from their distribution centers.

That decision was implemented largely in the year 2013, and Walgreens' involvement in the business of distributing

Schedule II drugs came to an end at that point.

Two other points on the distribution point before we break. This is testimony from John Coman. John Coman was the manager of the distribution center up in Woodland, and at the end of his deposition he was asked after having gone through any number of materials having to do with the operations of that distribution center with respect to suspicious order monitoring (as read):

> "Looking back on the documents that we reviewed today that begin in 2008 and similar notations that continue until 2011, do you believe that Walgreens deployed adequate resources within Woodland to perform due diligence on suspicious orders?"

He had a one word answer, "No."

Finally, if I may, Ms. Baig has made reference to our DEA diversion investigator James Rafalski.

Mr. Rafalski will testify that Walgreens failed to maintain effective controls against diversion of prescription opioids into the illicit market in violation of the applicable federal regulation; that Walgreens failed to design and operate a system to monitor and detect suspicious orders of controlled substances by its pharmacies in San Francisco and, for that matter, nationwide in violation of the security requirement of the same C.F.R.; and failed to conduct adequate due diligence on suspicious orders of opioids placed by Walgreens' pharmacies

in San Francisco.

And last but not least, if I may, Your Honor, in order to engage the impact -- remember, we're talking about suspicious orders, some of which may be okay, many of which probably weren't; but in order to gauge the impact of Walgreens' disfunctional suspicious order monitoring program on diversion of controlled substances in San Francisco, our experts analyzed the shipments of opioids to Walgreens stores in San Francisco for the period 2006 to 2014.

My understanding is they looked at all of the orders -- all the orders from San Francisco pharmacies that went to -- at least to the Woodland facility because that's the distribution center that would have fed San Francisco, using several different methodologies to identify suspicious orders; methodologies that were both used by some manufacturers and distributors and others that the experts concluded were appropriate means for identifying suspicious orders.

And the results of that analysis showed on a highly conservative -- and I want to emphasize this -- on a highly conservative basis that of those shipments, somewhere in the range of 20 to 25 percent were actually suspicious and should never have been shipped.

And that brings me to the end of the presentation on distributions and Walgreens, Your Honor.

THE COURT: Okay. Let me ask you, Mr. Heimann. How

much longer do you have today to roughly, ballpark?

MR. HEIMANN: My next subject is the third component of the case against Walgreens' dispensing. That's probably 45 minutes. And then Ms. Baig will follow-up with the impact on San Francisco, and she promises me that won't take more than an hour.

MS. BAIG: Less than an hour.

THE COURT: That will conclude, then, your opening?

MR. HEIMANN: Yes.

THE COURT: All right. So let's resume at 1:00 o'clock. 45 minutes for lunch. Thank you.

MR. HEIMANN: Thank you, Your Honor.

(Luncheon recess was taken at 12:14 p.m.)

AFTERNOON SESSION **1:00 p.m.**

THE COURT: Let the record show that all parties are present.

Before we commence with the opening statement, I want to just turn back for a moment to the document to which a privilege objection has been raised.

My understanding is that this document or series of documents -- and I should address Walgreens -- was presented to Judge Polster in the trial which he had before a jury and that he ruled -- he permitted it; is that correct? Or did not?

MS. SWIFT: Not exactly, Your Honor. He ruled on it long -- well, before trial.

THE COURT: Well, whenever. I mean, was --

MS. SWIFT: He ruled on it before trial. It did not come up at trial.

THE COURT: Oh, it didn't even come up at trial?

MS. SWIFT: It did not.

THE COURT: So it's never been -- has it ever been published -- quote, "published"; that is, released in a public forum?

MS. SWIFT: I'm honestly not sure, Your Honor. It's been used at depositions. We object. It's been produced over our objection in a number of cases.

THE COURT: Well, has it -- well, I have a slightly different question, and it may or may not make a difference. But has it been released publicly? Not whether it's been with Walgreens' consent. I'm just saying, is it out there or is it not out there? If you know.

MS. SWIFT: I don't know. I don't believe so, but I don't know, honestly.

THE COURT: Okay. So let's do this: If you would be so kind, would you identify the docket numbers in which you -- and I assume opposition submitted briefs --

MS. SWIFT: Yes.

THE COURT: -- on this subject and Judge Polster ruled on the subject. Can you just, you know, get your, you know, your friends there --

MS. SWIFT: We'll do that.

THE COURT: -- your friends to find out where on docket that is? Then I'll have access to it, I assume.

MS. SWIFT: We'll do that right away. Thank you, Your Honor.

THE COURT: Okay. Well, I'm not going to do it right away. I'm going to listen to the rest of the discussion, but at your convenience if you could give it to me, that would be helpful, yes.

All right. Let's continue. Thank you.

MR. HEIMANN: All right, Your Honor. May it please the Court, as I mentioned just before we broke, we're moving oh now to the dispensing -- liability case having to do with dispensing practices and procedures at Walgreens.

Let me start with what's called corresponding responsibility, if I may. And, again, we're talking now about a federal regulation, 21 C.F.R. 1306.04.

The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, the doctor, but the corresponding responsibility rests with the pharmacist who fills that prescription.

And what is that corresponding responsibility? To ensure that all prescriptions are valid and issued for a legitimate medical purpose by a practitioner authorized by law while acting in the usual course of his -- is that the regulation? --

his or her professional practice.

What does that mean in practical terms for pharmacists? Pharmacists have an obligation to identify indicia of possible diversion, commonly known in the industry and has been known for years in the industry as red flags, and to resolve any red flags before filling the prescription.

Let me emphasize that last point "resolve any flags before filling the prescription."

And it is the responsibility of the pharmacist to execute sound professional judgment in doing so.

So there is an obligation in terms of resolving the red flags to look at the red flag, to examine it, maybe to conduct an investigation in order to come to the conclusion whether or not it is or is not answerable in terms of whether or not the prescription should be fulfilled -- or filled. Excuse me.

But the pharmacies also have a corresponding responsibility to their pharmacists. First, to create systems and programs to enable pharmacists to perform their corresponding responsibility; second, to train pharmacists to comply with their corresponding responsibility; and, finally -- and this will become very important as we move forward into the evidence -- to provide pharmacists adequate time to perform their corresponding responsibility.

Beginning at least by the mid-1990s Walgreens had what they called or characterized as a good faith policy or good

faith practices, and that was intended to address the corresponding responsibility of pharmacists to identify red flags and to investigate red flags.

At that time there were only seven red flags in the system or in the documentation of their policy that remained unchanged for more than a decade.

But, perhaps, more importantly, during the period up until June of 2012, Walgreens utterly failed to promulgate and implement any kind of system to afford its pharmacists the means to resolve red flags.

Now, why do I say that? Well, here's what the pharmacists were instructed to do when they identified red flags during that time period (as read):

> "If a pharmacist is unable to dispense" -- this is one iteration of the written policy -- "If a pharmacist is unable to dispense a prescription in good faith" -- and what that is a reference to in context is, if the pharmacist identifies one or more red flags that would unless dispelled would prevent the pharmacist from dispensing in good faith, so this is a reference to identifying a red flag, that's just a long-winded way of saying if they identify a red flag -- "they are to contact the prescriber" -- this is the instruction to the pharmacist -- "contact the prescriber and confirm or clarify the prescription."

And if the prescriber says it is valid, that's it. Fill the prescription. Nothing more. Nothing more.

Now, language to this effect in one form or another was in the -- in all of the prescribing policies practices at Walgreens up until June of 2012. So for more than -- well over a decade.

Now, I would submit to Your Honor that on the evidence, this is an utter abrogation entirely of the corresponding responsibility on pharmacists to simply go back to the doctor.

Some of the red flags, I'm not going to go into them in detail now, but some of the red flags would have involved aberrant behavior on the part of the prescriber; pill mill doctors, for example.

But what pharmacists were told at Walgreens is: No matter what the nature of the red flag that you uncover, simply call the doctor. If the doctor says it's okay, that's it. Fill the prescription.

An example I'm going to give you of what that really means in practice comes from recent testimony by a Walgreens former employee in the Florida Attorney General trial.

The witness in question is Christine Lucas. Christine Lucas was in charge of the Jupiter distribution center dispensing of -- excuse me, not dispensing -- distributing CII, Schedule II, drugs to the various pharmacies. She was the one who did basically the mechanical distribution to the pharmacies

that ordered from Jupiter.

In about 2009 or 2010 -- I'm not sure the precise date -- the law in Florida changed. Up until that time, prescription clinics were allowed to prescribe and fill prescriptions for opioid drugs directly.

And there were at that time a good many of these pain mills, I would call them, and that was causing a serious problem with dispersion because of over-distribution or overprescribing and dispensing of drugs.

So the law in Florida changed, and what the change amounted to is these clinics could no longer dispense directly so they had to send their prescriptions to pharmacies like Walgreens to get filled instead.

And that led to an enormous increase almost overnight of prescriptions being presented to pharmacies like Walgreens, and that in turn led to an incredible increase in orders by Walgreens' pharmacies to the distribution center.

The magnitude of those orders was off the wall and was noticed as such by, among others, Christine Lucas who raised questions about it, including sending e-mails on multiple occasions up to Walgreens corporate asking: What's going on? Is anybody looking at these orders to see whether or not they're legitimate or not?

And one of the things that she did when she was wrestling with this issue, is she talked to some of the pharmacists who

were placing these orders with the distribution center to find out about what they were thinking and what they were doing.

And this is what she testified to about the conversations that she had with some of those pharmacists when she was trying to figure out why they were ordering such extraordinary quantities of drugs for their stores.

(Video was played but not reported.)

MR. HEIMANN: "I'm not a doctor. I'm a pharmacist." So they were following essentially Walgreens' policy: If the doctor says it's okay, dispense. That's the end of your responsibility.

That, as I suggest to Your Honor, is an abrogation of their obligation under corresponding responsibility.

Now, that did finally change, but it didn't change until June of 2012. And you remember the timing of some of the stuff I said earlier to you.

The DEA was hard onto Walgreens beginning in 2009 -- I'll come back to that in a minute -- and in 2012 is when they shut down the Jupiter facility completely in December of 2012.

So what was that change? Here is the language from the June 2012 policy (as read):

"If the prescriber informs the pharmacist" -- this is another situation I've left off the beginning part, which is "If you identify a red flag, you identify one or more red flags, contact the prescriber. If the prescriber

informs the pharmacist that a prescription for a controlled substance is valid but" -- and here's where the corresponding responsibility comes into play -- "but the pharmacist determines that the elements of good faith dispensing are not present, the pharmacist has a responsibility to refuse to dispense."

That's what corresponding responsibility is all about, that which has been abrogated for all of the years leading up to June of 2012.

But how did that change come about? Was that something that Walgreens identified themselves and voluntarily realized, "Oh, we haven't been doing that right"? Not a chance.

In September of 2009, the DEA issued an order to show cause to Walgreens with respect to a pharmacy in San Diego asserting multiple violations of the Controlled Substance Act with respect to this dispensing of controlled substances by that pharmacy.

These included dispensing controlled substances to individuals based on prescriptions by physicians not even licensed in California, dispensing controlled substances to individuals located in California based on internet prescriptions where the doctors hadn't even seen the person to whom the medications were prescribed, and dispensing controlled substances to individuals that Walgreens knew or should have known were diverting the controlled substances, and, finally,

refilling prescriptions too early.

And that's an important red flag obviously. If you've got a patient that's coming back 10 days early or 15 days early and asking for a refill, that's a red flag. That may be someone who's using opioids not for medical purposes but because they're addicted.

In internal e-mails Walgreens corporate explained the connection between the DEA's action in this regard and the revisions they made to their dispensing policies, and that's right here.

This is the then head of Pharmaceutical Integrity, I believe, writing (as read):

> "We are having to enter into an agreement with the DEA based on an issue in a California store."

The agreement she's referring to was one that the DEA insisted on include a compliance program and procedures to identify red flags, procedures that had not existed before, a program that simply did not previously exist in any form or any coherent form.

The DEA also insisted that Walgreens provide periodic training to its employees for dispensing controlled substances training which did not exist at that time either.

So in March of 2011, Walgreens entered into a memorandum of agreement arising out of this action against the San Diego pharmacy with the DEA and the Department of Justice, which

provided in part that Walgreens agrees to maintain a compliance program to detect and prevent diversion of controlled substances as required by the CSA, the Controlled Substances Act, and applicable regulations.

And the program was to include procedures to identify the common signs associated with diversion, meaning red flags, including, but not limited, to doctor shopping and requests for early refills and the sort; and the program shall include routine and periodic training of Walgreens' employees, particularly their pharmacists, in their obligations to perform their corresponding responsibilities under the CSA.

Now, as I mentioned, that was in March of 2011, but it still wasn't more than a year before they finally changed that "just rely on the doctor" policy because that didn't come about until June of 2012.

But, once again, that change was linked to action by the DEA, not voluntarily undertaken by Walgreens. And that's, again, shown in another e-mail or this is -- I think this is either an e-mail or a PowerPoint presentation that was made by the Pharmaceutical Integrity folks through others at Walgreens, and it links the June 2012 change directly to the DEA action (as read):

> "Due to recent action taken by the DEA, select policies and procedures have been updated to ensure our pharmacists and stores are compliant with dispensing

controlled substances."

In November 2012, Walgreens' personnel attended presentations by representatives of the DEA at the National Association of Boards of Pharmacy, I think it's called, an organization that is for pharmacists and pharmacies.

Walgreens -- at that meeting were representatives of the DEA, including a name that Your Honor will become familiar with as we go forward, Joseph Rannazzisi, who was the then head of disbursement enforcement at the DEA, and he was the author, incidentally, of those three letters from 2006 and 2007 that we talked about this morning.

And among the notes that the Walgreens people who were in attendance at that meeting took about what Mr. Rannazzisi had to say at that time were these (as read):

"A pharmacist is a professional and shouldn't be filling every prescription that comes through the door."

Mr. Rannazzisi and the DEA believe that pressure from owners/operators to fill scripts is driving the problem. The problem being diversion.

And we'll come back to this in a few minutes because this is a major problem that was identified at Walgreens going forward for years. (As read):

"If suspicious, you don't ship." Now he's talking about distribution. "Decreasing the order in shipping is not in compliance with the regulation."

And he said that the DEA was hearing complaints from pharmacists that they don't have enough time to check the prescriptions for good faith, meaning to investigate the red flags when they were identified, or let alone to identify red flags; and he wants to make sure that chains are not inhibiting this by pressuring your pharmacists to fill fast or not provide the adequate labor.

And, again, I'm going to come back to this in a moment both with respect to staffing, the adequacy of staffing at Walgreens stores to enable pharmacists to do their job and also the adequacy of the time available to pharmacists to do their job.

These are going to be two major issues that will go forward as problems with Walgreens and the dispensing practices at the Walgreens pharmacies.

And, finally, Mr. Rannazzisi said that he believes that compensation bonus should not be tied to prescription volumes of controlled substances as it was at that time at Walgreens.

And ultimately that policy was changed but was not necessarily changed in a way that was effective, as will come forward either later today or during the course of the presentation of evidence.

And in a January 2013 presentation, the director -- then new director of Pharmaceutical Integrity, a lady by the name of Polster, Tasha Polster, explained dispensing practices and

policies in this fashion (as read):

"In June" -- now she's talking about June of 2012. That's when that policy was changed so that you no longer just go to the doctor -- "In June we relaunched our good faith dispensing policy. However, we have learned more about DEA's expectations around GFD" -- that's good faith dispensing as if they didn't know about it before -- "and we felt the steps we were talking with good faith dispensing did not go far enough."

"The game has changed. We can no longer rely on the 'I spoke to the prescriber and he said it was okay'" -- what they had been relying upon for decades before then.

One of the changes that was announced around that time was the creation of what was characterized as a target drug good faith dispensing policy.

So up until that time, there is dispensing policy and practice was good faith dispensing. Now they alter it to be target drug good faith dispensing.

And what did that mean? That they would identify certain drugs as particularly problematic, and that they would ask or require additional procedures be performed by their pharmacists with respect to those drugs, and I'll come to that in a moment.

But that policy was under -- even when that policy was under development and it was intended to provide those procedures, one of the procedures included a checklist for

so-called target drugs.

But from the outset of the program, it was highly limited. By that I mean, first, a new policy was limited only to three drugs: Oxycodone, hydromorphone, and Methadone, and then only in single-ingredient form. So it did not include any opioid containing those ingredients where -- in combination with other drugs.

So, for example, it didn't include Percocet, Vicodin, Norco, Opana, Kadian, some of the most prescribed drugs on the market during that time period. They were all highly addictive and highly dangerous.

And it didn't include hydrocodone. At that point in time hydrocodone was only a Schedule III, but it was on its way to Schedule II; and it became a Schedule II within a fairly short period of time after this, but it was recognized at that time universally as the most commonly abused opioid in the nation; but it was not included on the target drug list of three.

Despite these improvements, over time and as belated and limited as they were, there were still persistent problems that continued at Walgreens for years.

First, a continuing emphasis on sales and filling prescriptions. This is an e-mail from a Walgreens pharmacy supervisor to Walgreens corporate commenting on the oxycodone dispensing activity in Florida stores in August of 2010 (as read):

"Great info. This is an entire month and all" -- "and" -- it should be "on," it was a typo in the e-mail -- "on all strengths. Please look at stores at the bottom end."

So this writer is concerned with stores at the bottom end, meaning stores that aren't -- right? -- filling enough prescriptions, particularly for oxy -- opioids, inappropriately. (As read):

"We need to make sure we aren't turning away legitimate scripts. Please enforce."

Who's the "please enforce" to? That's to the management of the pharmacies, the managers who manage the pharmacists, telling them to enforce -- make the pharmacists writing -- filling prescriptions for drugs that are prescribed by physicians.

And corporate's response to that e-mail? (As read):

"We have a wide range of oxycodone business in our stores. The busiest store in Florida is Orlando. Almost 18 oxycodone prescriptions per day. We also have stores doing about one a day. Are we turning away good customers?"

And this is a presentation on pharmacy manager bonus programs in December of 2010 (as read):

"The purpose of the bonus is to recognize and reward persons responsible for improving pharmacy operations.

How so? The best evidence of a well-run pharmacy is the increase in prescriptions and pharmacy sales."

And this from a couple of years later from a corporate VP regarding an update for the Western Division in February of 2012 (as read):

"We have to strive for the activities that drive incremental scripts. There are metrics we can improve today that will demonstrate the," quote, "doing whatever it takes to achieve 100 percent of fiscal year" -- I assume that's fiscal year 2011 -- "script volume."

So the point here is that Walgreens corporate was sending the message down to their managers at the district level and at the pharmacy level that corporate wanted sales. They wanted prescriptions filled. That was a priority. And that was the message that got through from management to the pharmacists behind the counter.

As late as 2014 -- 2014 now -- Walgreens developed a program to identify pharmacists who were not filling enough opioid prescriptions called the pharmacists nondispensing report. And here is an e-mail talking about it (as read):

"Ed and Jeff" -- Ed and Jeff were two employees in the pharm -- I believe in the Pharmaceutical Integrity unit, a unit comprised of some 10 or 12 individuals -- "developed a report that supervisors" -- meaning business people now -- "will be able to use in order to see

pharmacists in their districts that are not dispensing a lot of controlled drugs. Bad. Not dispensing a lot of controlled drugs."

The intent is to give visibility into whether or not we have pharmacists that are concerned -- I'm adding my own language in here -- about the efficacy and propriety of opioid use for chronic pain because that's what they're really talking about.

Are you concerned that pharmacists just won't fill a controlled med or maybe are selective about filling them?

And part of this plan with respect to this -- to this new -- the nondispensing report and the directions given down to the business people for how to deal with these pharmacists who weren't up to snuff in terms of the amount of opioid prescriptions they were filling was continuing education, to have them -- subject them to continuing education programs prepared at the direction -- well, I'll come to that.

So here's the e-mail. This is the head of Pharmaceutical Integrity responding to her subordinates' development of this program. She says (as read):

"Encourage the pharmacists, the low-filling pharmacists, to obtain more information on pain management, such as continuing education courses, in order to better understand treatment protocol and feel more comfortable in filling controlled substances."

Now, let's keep in mind the time period we're talking about. We're in 2014 now. The opioid epidemic has been raging for more than a decade. It's probably at its height in terms of prescription opioids, or close to it.

So naturally pharmacists see this. They understand it.

We heard a little bit ago when Ms. Baig was here, she had the testimony of one of the folks from Walgreens acknowledging they were aware of the epidemic. They knew what was going on. They knew why it was going on from diversion of controlled substances.

So it's natural that Walgreens in 2014 would have any number of pharmacists that were concerned about whether or not they should be filling prescriptions for these kinds of drugs for the kinds of patients that were coming in.

And these materials that Ms. Polster is encouraging her subordinates to present to the low-filling pharmacists, these continuing education programs, were those programs that often were either written by or financed by the manufacturers of opioids, like Purdue and Endo.

You know, you'll likely hear from Walgreens that in the early period of what I've characterized as Walgreens' collaboration particularly with Purdue, you may hear from Walgreens that they too were duped about the science; that their pharmacists weren't any better than the doctors at knowing what the science actually was and so they could have

been fooled.

But this was a recurring theme in Walgreens even as late as 2014. For example, you remember the e-mail I showed you a bit ago about -- the e-mail exchange about oxycodone business in Florida.

Here's the suggestion Walgreens corporate made as a way to induce pharmacists to fill more oxycodone prescriptions at that time (as read):

> "Please review the stores in your district and use the continuing educations that I sent out a couple of weeks ago."

Those continuing education programs that this gentleman is referring to were the pharmacist's role in pain management, a legal perspective, and navigating the management of chronic pain, a pharmacist's guide, two CEs, continuing education programs, financed in the first instance by Purdue and in the second by Endo, each of which contained multiple, multiple misrepresentations about opioids and pain management.

The same type of lies that Purdue told in the late 1990s and early 2000s in the continuing education programs that they sponsored at that time in which they provided at Walgreens' request to Walgreens to use with Walgreens' pharmacists to reeducate or to educate them at that time.

But coming back to the notion of the overriding goal being more profits, more sales, more filling of prescriptions -- and,

by the way, filling prescriptions is the lion's share of revenue for Walgreens over everything else. It's their prescription business that drives the revenue of the company.

This is the message that went to the heart of Walgreens' business philosophy to pharmacists about what they should do in terms of their good faith dispensing activities (as read):

"Good faith dispensing concerns don't relieve you from trying to attain the numbers that have been set for you" -- "the numbers that have been set for you in terms of prescriptions to be filled," the quota.

In 2015, Walgreens conducted a survey of some 2,400 stores -- now I'm moving on to another aspect of the problems at Walgreens -- to determine the level of Walgreens compliance with the memorandum agreement that they had with the DEA and the DOJ that I described a few moments ago. It was called the basic control initiative.

The idea was to see whether or not Walgreens' pharmacists were actually doing what they had been instructed to do with the relaunched, as they called it, good faith dispensing practices and with respect to the target drug good faith dispensing policies.

The results weren't good. So as we see here, this is a slide presentation concerning this basic control initiative in order to check if stores are compliant with the policies and procedures put in place (as read):

"Per the MOU" -- excuse me -- "memorandum of agreement, a random sample size audit was conducted in June. Results were unfavorable."

Less than 60 percent of the stores were compliant with respect to the target drug checklist being attached to prescription hard copies, and in some three quarters or only three quarters of the stores were compliant with attaching refused PD prescription hard copies so that there would be a record of why the prescription was refused.

Now, as I said, in addition to the focus on profits and selling more opioid prescriptions, there were other major flaws in Walgreens' dispensing system.

The first had to do with inadequate software capacity. Now, that may not seem significant at first blush, but actually it is.

Under the target drug good faith dispensing policy that was put in place in 2012, 2013, 2014, the target drug checklist -- and I haven't got one to show you, but it's basically a list of potential red flags. You're supposed to check and see whether or not these things are apparent or not with respect to the -- each individual prescription that they were being called upon to fill.

But at that time they had to fill that out in hard copy, and they couldn't be -- it could not be stored electronically in the patient's prescription -- electronically stored

prescription record.

Instead, it was kept in hard copy at the pharmacy itself and stored in a file drawer or in a folder, whatever, but not with the prescriptions for the patients themselves.

And what did that do? Well, it made it difficult even for the same pharmacy store when the next prescription comes in to check back to see what had happened with the earlier prescription for an opioid.

And, of course, it made it literally if not impossible, nearly impossible if the patient went to a different Walgreens store the next time because that different Walgreens store wouldn't have the record of what happened in the earlier prescription, particularly if the prescription, for example, had been denied for reasons that had to do with the failure to pass good faith dispensing practices.

This issue was not just a theoretical issue. This was actually raised by Walgreens pharmacists at the very time that the new system was being pilot tested.

Here's an example of that. This is one of many. So here's a pharmacist writing in to Pharmaceutical Integrity again, because that was the place you raised these kinds of questions, and the question was (as read):

"In order to determine when the last time Q11 was completed" -- I believe that's a reference to the checklist -- "can we scan in the checklist as an

additional image rather than having to go back through the hard copy filed scripts to retrieve? It would be easier for us to look through the scanned images."

Well, of course it would be, but what was the answer? (as read):

"No. IC+" -- IC+ is the term for the software electronic storage facility that Walgreens was using at the time -- "IC+ does not have the memory capacity for all those images."

So, no, you get it in hard copy and that's the only way you get it.

And this wasn't the only problem. In the IC+ software there was a section for comment field, and that comment field for a prescription and a patient was intended primarily to record reasons for denying prescriptions or perhaps reasons for granting prescriptions, even though a red flag had been identified.

So if the prescription gets denied because it doesn't pass good faith dispensing, those comments go in that field, presuming it should; and if the red flags are identified but cleared, those comments should go in the comment field.

It's a really important field for the next time a pharmacist is confronted with the same patient with another opioid prescription.

The field -- but, again, there was no way, given the

system at the time, that that could be done on an ongoing basis. Why was that? Because they didn't have enough room.

And this too was raised by pharmacists right at the outset when the new -- new program was going into effect in the 2012, 2013, 2014 time period. And this is just one example of many where a pharmacist writes in again to Pharmaceutical Integrity saying (as read):

"Apparently there is a limit to the amount of characters we can put in a patient's comment section."

That's right. There was. "How can we overcome this as the area fills up?"

The answer (as read):

"Tough. Just make sure the most recent comments are in there and delete the oldest."

Although, of course, the oldest might be the most important when it comes to the next prescription from that patient that comes into the store.

For six or more years the folks at Pharmaceutical Integrity asked for the electronic software program to be improved, updated so that these serious problems could be addressed. And for six years or more, they went begging.

Finally at the end of 2019 -- end of 2019 -- the system was partially enhanced to at least allow the checklist to be completed and retained electronically.

And how did the head of Pharmaceutical Integrity -- that's

Ms. Polster again -- greet this change? This way (as read):

"I have been waiting to do this from day one" --

Day one. She was made head of Pharmaceutical Integrity at the latter part of 2012. So seven years earlier (as read):

"I have been waiting to do this from day one and Kermit wouldn't let me.

And that's not Ms. Piggy's Kermit. That's Kermit, CEO of Walgreens, c'est moi.

(Laughter)

MR. HEIMANN: Moving on. Bad docs, another problem. Yet another major failing had to do with bad doctors by which I mean doctors who were obviously overprescribing controlled substances, pill mill doctors and others whose prescribing practices were highly suspicious.

Walgreens had the ability and, in fact, did at corporate level identify such doctors, high-prescribing doctors, from data that was available to Walgreens at the corporate initiative level.

Remember, Walgreens had insight into all prescriptions filled by their stores nationwide by patient and by prescriber. So they used that data to create a system to identify problematic doctors.

This is an example. A prescriber index. And what they did was they used a variety of metrics to identify doctors that were at best dubious if not worse. So they ranked them by pill

mill volume, percentage of total prescriptions that were target, maybe those three target drugs, number of patients who paid in cash because patients paying in cash was another indicia of possible diversion, and sudden increases in these -- and this is just a few of the metrics that they used to identify doctors that they recognized were potentially, if not actually, seriously problematic.

So they had that ability at the corporate level. Now, one would think that that would be valuable information to communicate to pharmacists on the line who were being confronted with prescriptions written by these doctors.

And did they do that? Did they provide that key data, that critical data, to their pharmacists? Let's see.

Here's Eric Stahmann. Eric Stahmann was part of Pharmaceutical Integrity, a manager. He was a manager for the Western Region. His deposition was taken recently, and here's what he had to say about that.

(Video was played but not reported.)

MR. HEIMANN: Think about that. Corporate had a policy, a directive, that the pharmacists were not to be provided data that corporate had identifying doctors who were highly questionable so that the pharmacists could be aware of that when evaluating prescriptions written by those doctors.

They didn't want to cloud the judgment of their pharmacists.

Now, why would that be? Why would they not want their pharmacists to have that information?

Could it be because it would be more likely that a pharmacist without that information would fill those prescriptions rather than reject them?

This had real consequences incidentally in San Francisco. For example, here is a screen shot of that prescriber index this time using a metric of prescribers -- top 25 prescribers in the U.S. for hydrocodone. Remember, that's one of the seriously abused drugs in the opioid field.

And if you look down a little closely, you'll see a doctor identified as Ray Seet, S-E-E-T, as one who appears on that list.

Now, who was Dr. Seet? Dr. Seet was a physician with offices in Petaluma, California, who wrote lots and lots of opioid prescriptions. And he was identified no later than 2012 by -- at corporate level as a problematic doctor.

Notwithstanding that, Walgreens pharmacists still filled almost 800 more prescriptions by that doctor after he was identified for opioids by Walgreens San Francisco Bay Area stores.

In fact, Walgreens continued filling prescriptions from Dr. Seet almost a month after the California Medical Board terminated his license in 2013.

There were any number of indicia prior to that time that

would have raised serious questions about Dr. Seet, but Walgreens pharmacists who were presented with those prescriptions were never told about what corporate knew about the history of Dr. Seet.

98 percent of Dr. Seet's San Francisco opioid prescriptions triggered at least one red flag. That's information that corporate should have known and probably did.

A second example, Dr. Guido Gores. Dr. Gores had an office in San Francisco on Hyde Street; and as it indicates here, between 2006 and 2020 Walgreens filled more than 10,000 Dr. Gores opioid prescriptions even though 83 percent triggered at least one red flag during that time period.

In addition, by no later than 2012 Walgreens prescriber index had identified him as being a top 1 percent -- in the top 1 percent of opioid prescribing.

In fact, even though corporate didn't advise the pharmacists in San Francisco after that about this doctor, many years later in 2019 one of the Walgreens stores, the one at Market and 9th -- we all know where Market and 9th is -- adopted a policy to stop filling any of his prescriptions. In another store, this one at Bush and Larkin followed suit a few months later.

And then by September, Walgreens finally becomes aware of a DEA investigation when it provided documents to the DEA concerning the doctor, but it still continued to fill hundreds

of Dr. Gores' opioid prescriptions after that. Finally in 2021, Dr. Gores ceases to become -- ceases to be a doctor.

So, as I said, the failure on the part of Walgreens to provide the information that it had at corporate to the pharmacists on the line has real consequences.

Another problem, even when individual pharmacists are identified by -- even when individual pharmacists at the stores identify a problematic doctor, they had no way to systematically inform other pharmacists at Walgreens stores about what they knew.

In fact, two policies of Walgreens actually inhibited pharmacists from access to critical information to use in their efforts to comply with their corresponding responsibility.

First, pharmacists were instructed by corporate Walgreens that they absolutely could not bar or ban a doctor wholesaler.

No matter how bad the history and record of the doctor was, no matter how obvious it was that the doctor was a pill mill doctor, Walgreens pharmacists were forbidden from banning such doctors from refusing to fill such doctors' prescriptions across the board.

For example, and here's just one, when informed about a doctor who had been banned by the CVS pharmaceutical chain and who was in the 98th percentile for oxycodone and 97 percentile for hydrocodone and who had 860 prescriptions were filled within the preceding 90 days, 76 percentage of which were for

controlled substance, this is how Pharmaceutical Integrity responded to the pharmacist on the line who was asking for help: What can I do about this doctor? And this is what they told him (as read):

> "With all that having been said" -- meaning with all this history of this conduct by this doctor and his prescribing practices -- "as long as the doctor has a valid DEA and state license, you've got to fill. We should in no circumstances be blanketly refusing prescriptions."

Instead they were told: Treat -- effectively what the pharmacists were being told is: Treat this doctor like you would any other doctor in applying your good faith dispensing policies.

So the pharmacist was instructed effectively not to take into account the history of the doctor because they hadn't been provided the history of the doctor by corporate who had the information but chose to withhold it.

In another instance with a similar doctor and a pharmacist was asking for help from Pharmaceutical Integrity, here's what Pharmaceutical Integrity said (as read):

> "Regardless of a prescriber's prescribing history, if they have a license, we can't blanketly refuse or systematically deny his prescriptions."

In addition to this, pharmacists were even forbidden by

corporate policy from noting in the pharmacy records of the prescriber the character of such obvious pill mill doctors.

So even if the pharmacists identified such a doctor as we saw a few minutes ago they did in the case of the doctor who I showed you, they weren't permitted to make notations in the prescriber's record at the pharmacy about that.

Here's a situation: When a pharmacist, again, was asking "What can I do," they say (as read):

"Comments in IC+ for prescribers" --

Let me back up. (as read):

"Comments in IC+ for prescribers" -- so they had a computerized electronic record by prescriber -- "should be limited to the following caution use GFD, standard caution for everybody.

"Any comments, such as prescriber under investigation, in the prescriber's profile should be removed. Refrain from making any statements about the prescriber or patient."

That's just one of many examples. Here's another (as read):

"Advise the pharmacy staff to refrain from entering any slanderous comments like 'pill mill doctor' or 'watch out' in the prescriber's IC+ profile and stick with the very generic comments, such 'As verify GFD.'"

Walgreens' corporate was well aware of other problems

arising from the target drug good faith policy and program.

Concerns over how the target good faith dispensing policies were overtaxing pharmacists -- remember, I mentioned that we were going to come to this -- where overtaxing pharmacists were identified and communicated to corporate even during the early stages of the testing of the new TDGFD program.

For example, here's a report on store visits in February of 2013. February 2013, so shortly after they devised the new program and now they've got it in a pilot mode in certain stores. They sent out folks to go to those stores to see what the impact of the new policy was on pharmacists at the stores. And here's what was reported back (as read):

"Two biggest issues in centralization markets. High volume stores does not seem to be enough labor to perform all the tasks.

"Secondly, fatigue and sustainability of our pharmacists is a real concern. We're asking them to do a lot, but how long can they continue?"

They're asking them to do a lot because they were putting additional obligations on the pharmacists that they had never had before with respect to this target drug good faith dispensing program. (As read):

"When they don't meet the goals and standards on everything, they feel like they are failing."

And I'm going to come to that a little bit more towards the end of this presentation about dispensing.

With respect to this notion of stressing pharmacists and adequate staffing to do all that they were being called upon to do according to the written guidelines, in 2019 Walgreens engaged the services of a Tata Consulting to look into a number of Walgreens' issues, including stress levels among pharmacists.

The findings as presented to a Walgreens' executive included, and I'm going to show you now a slide from an early draft of the report from the consulting firm about what they had found and I've highlighted certain of the findings. (as read):

> "We heard reports, multiple reports" -- so this is reports from pharmacists -- "of improper behavior which was largely attributed to the desire to keep below promise time."

Now let me tell you about promise time. For those of us who've stood in lines at Walgreens pharmacies many times, the policy at Walgreens was -- I think it still is -- that the pharmacist was expected to fill a prescription that was presented at the store, presented to the pharmacy department, within 15 minutes of the prescription being presented.

And if you've ever stood in a Walgreens store in those lines and you see people come up one after the other presenting

prescriptions for filling, you can imagine how difficult a job that is for the pharmacist behind the counter, particularly if there's only one pharmacist there, which we'll come to in a little bit in terms of staffing.

They -- the report went on (as read):

"All participants expressed a high level of stress in trying to meet promise time, and the belief that given the current level of staffing, promise time was unreasonable while following proper procedure."

Proper procedure? Good faith dispensing policies and practices. That's the procedure they're talking about. (as read):

"One said that they are so much concerned about taking their lunch break as they will feel they are judged for not making promise time following the lunch break and they said they cut their lunch break short.

However, senior leaders at Walgreens were not happy with these findings and, in fact, they actually directed the consultants to remove some of the more damaging findings, including, as it turned out, this slide in its entirety, which does not appear in the final form of the report from the consulting report.

Other key findings were also altered. For example, here is the language that appeared in the -- in an earlier draft version of the report (as read):

"Proper procedures are sometimes skirted or completely ignored due to worries of meeting promise time."

Now, what procedures are they talking about? The good faith dispensing procedures. Those are the important procedures that the pharmacists were reporting to the consulting investigators were sometimes skirted or ignored because of the requirements of promise time.

Was that included in the final? No. It was modified at the instruction of senior Walgreens' people to read (as read):

"Promise procedures are sometimes perceived as barriers to addressing all necessary pharmacy tasks."

So the meaning is altered in a significant way.

Once again, as we did with the distribution issue, in order to gauge the impact of Walgreens, in this case, disfunctional dispersing policies and practices on diversion of drugs -- controlled drugs in San Francisco, our experts analyzed prescriptions filled by Walgreens stores in San Francisco during the period 2006 to roughly mid-2020.

And in doing that, we used multiple criteria, or red flags, against the actual records of the prescriptions that were filled and the data about them to identify prescriptions that were filled but that showed red flags.

The analysis revealed -- and, once again, on a highly conservative basis -- when we present the evidence, we'll

present the various percentages that this analysis showed; but on a highly conservative basis, this is what it showed:

60 percent of the opioid drugs and opioid-associated drugs triggered one or more red flags. 60 percent of those prescriptions that were filled.

Another effort that we undertook to gauge the impact in San Francisco has to do with documentation.

Walgreens had an express policy in place, I think for most, if not all, of the time we're talking about, that pharmacists were required to document in writing the reasons for particularly if they denied a prescription, refused to fill it, or did fill it, to document the reasons with respect to their good faith dispensing policy.

So, for example, if they found a red flag, they were supposed to document that. If they resolved that red flag in favor of dispensation, they were supposed to document that. If they found a red flag and they didn't resolve it, they were supposed to -- and didn't fill the prescription, they were required to document that.

So one of our experts, Elizabeth Park, who is a pharmacist and practices in the field of reviewing pharmacy practices, examined what Walgreens told us were the complete documentation of their due diligence for some 2300 filled prescriptions subject to one or more red flags. So what we're talking about here are prescriptions that were recognized as having one or

more red flags attached to them but were filled anyway.

So, presumably, if one was doing your job right, you would have written down the basis upon which you resolved the red flag. That should have been documented in the materials that Walgreens provided to us.

Well, what happened? In this examination she concluded that fewer than 5 percent of those prescriptions contained adequate evidence of due diligence to solve or address the red flags that were identified.

In addition to all of that evidence from the files and records of Walgreens itself, we will be offering the testimony of Mr. Catizone, the former executive director and CEO of the National Association of Board of Pharmacy. And Mr. Catizone will testify about Walgreens, that based on his analysis of Walgreens' practices and policies, Walgreens had inadequate policies, procedures, and systems to detect diversion; that Walgreens had a history and pattern of filling opioid prescriptions without resolving and documenting the resolution of red flags; and that corporate performance metrics at Walgreens undermine compliance with corresponding responsibility.

Finally, Your Honor, we will be presenting the testimony of a number of current and former Walgreens' pharmacists about the problems that they encountered and dealt with while employed as Walgreens pharmacists. Many of them are things

I've already mentioned; but among the other things -- among the things that they will talk about is the -- again, the prioritization by the company of filling prescriptions and prioritizing filling prescriptions faster, constant pressure to fill and to fill quickly.

They'll talk about the 15-minute wait time and the impact it had on their ability to perform their corporate responsibility with respect to good faith dispensing, and the fact that they were often forced to cut corners with respect to that because of the 15-minute deadline.

They'll talk about inadequate staffing and how inadequate staffing also undermined their ability to perform their good faith dispensing responsibilities as pharmacists.

They will tell you about how they were often penalized by management for failing to fill prescriptions for controlled substances; and how their failure to fill prescriptions when seen by management impacted their performance scores, which in turn impacted their advancement in the company and their compensation.

They'll talk about the fact that the good faith dispensing practices weren't audited or monitored by management in any effective way on an ongoing basis.

And they'll talk about what I also mentioned a little bit ago, the drugs that are high for diversion and abuse are not included on the target drug list, the three-drug list, and

many, as I noted before, are not on the list at all.

And, finally, they'll talk about how management reprimands pharmacists for refusing to fill prescriptions for controlled substance; and that the whole notion that businesspeople supervise and rate pharmacists presents a conflict of interest because the businesspeople are interested in the business and the pharmacists are interested in the patient's health, and there is a conflict when the latter are controlled and directed by the former.

I want to give you in closing my portion of this anyway, just a snippet from two of the pharmacists who will testify before Your Honor.

This is Rebecca Gayle, who was a pharmacist with the -- in San Francisco for some five years in the mid-2011 to 2016 time period.

(Video was played but not reported.)

MR. HEIMANN: And now Golnaz Kamali -- I hope I'm pronouncing that right -- who was with Walgreens for the same period of time but in the Los Angeles area.

(Video was played but not reported.)

MR. HEIMANN: And that's dispensing, Your Honor.

THE COURT: Thank you.

We'll take a recess until 2:15.

(Recess taken at 2:01 p.m.)

(Proceedings resumed at 2:15 p.m.)

THE CLERK: Come to order.

Court is now in session. You may be seated.

THE COURT: Okay. Let the record show all parties are present.

You may proceed.

MS. BAIG: Thank you, Your Honor.

OPENING STATEMENT

MS. BAIG: Your Honor, the conduct that we've spent the better part of today discussing --

THE COURT: Why don't you move the microphone closer to you. Okay?

MS. BAIG: Closer to me?

THE COURT: Yeah. We want to make sure it's on.

MS. BAIG: Better?

THE COURT: I think so. Thank you. Yeah.

(Pause in proceedings.)

MS. BAIG: What we have spent the better part of today discussing, the masterful promotion which was false and misleading, combined with the incredible pressure and incentives set up for sales employees to aggressively grow sales of controlled substances and the practically nonexistent SOM systems, all of this had a devastating effect on our country and on our beloved San Francisco.

Time permitting, we expect to call a number of the following witnesses to testify with respect to the scope of the

nuisance right here in San Francisco outside our courthouse doors.

(Pause in proceedings.)

MS. BAIG: San Francisco, just 47 square miles with about 875,000 people and more than 40,000 people living with opioid use disorder, with Walgreens being the primary opioid dispenser across the city, with the top six Walgreens dispensing locations ranging from 102 million morphine milligram equivalents to 416 million morphine milligram equivalents from 2006 to 2020, and with dispensers receiving nearly 8.8 billion MMEs between 2006 and 2014, enough for every resident, not just those in pain but every adult and child to consume over 1200 MMEs per year.

That consumption and oversupply continues to wreak havoc in every corner of our city, and the city struggles mightily to combat the problem.

Take, for example, the San Francisco public library, one of the premier national urban libraries, 28 branches, millions of visitors yearly. One of the main branch's largest challenges is the opioid epidemic. 65 staff members had to be trained with Naloxone in 2016 so they could revive people on the premises.

Sheriffs have to maintain a presence to assist with responding to overdoses. Needle boxes and toilet grinders required to help with the excess needles and drug debris.

Certainly not how librarians should be forced to spend their time.

San Francisco's Zuckerberg General Hospital treats 10 to 20 people a day for opioid overdose or addiction, which its chief of emergency medicine, Christopher Colwell will testify is San Francisco's most immediate threat.

Up to 25 percent of all visits to the emergency department in a given day that are opioid related.

Chief Colwell recently treated a physician, two nurses, a professional athlete, a drug dealer, a lawyer, two teenagers, and a 7-year-old girl who got into her mother's purse.

We will hear from Dr. Phillip Coffin, the director of San Francisco's Center On Substance Use and Health at DPH. He's looked at the San Francisco data on opioid use disorder and overdose for over a decade. His review of the data shows that with an increase in supply of opioids, we see an increase in people with OUD and an increase in overdose deaths.

From his review of the data, he described San Francisco's experience of the epidemic in three waves.

First, beginning in the late '90s, 1990s, a flood of pills accompanied a high incidence of OUD patients.

Second, beginning in about 2010 to 2012 timeframe, San Francisco's overdose rate was 2.23 times the national average. More than 93 percent involved prescription opioids.

Third, beginning in about 2015, overdose deaths increased

by more than 478 percent.

His review of the data shows that many were addicted to prescription pills and later turned to heroin and fentanyl.

The Department of Public Health physician Dr. Joseph Pace has been treating patients largely in the Tenderloin for about 20 years. He often stops and checks the vitals of potential overdose victims lying on the street as he walks to work.

He will testify about having bought into many of the promotional messages circulated by defendants earlier in his career and how he had to shift his thinking on appropriate prescribing as the crisis emerged.

He will also describe the challenges he's faced in treating patients with chronic pain and opioid use disorder, and how San Francisco implemented a harm reduction program to try to save lives and otherwise improve outcomes.

Dr. Barry Zevin has also been a treating physician for decades. He treats San Francisco homeless population for opioid use disorder. He came to San Francisco in the early '90s to treat HIV patients when there was no medication at all.

He observes that San Francisco's current drug scourge is as bad or worse than that era. He has learned that approximately half of his patients with opioid use disorder report their initial opioid use was with prescription opioids. And he will testify that overdose is the number one cause of death for the homeless community that he serves.

San Francisco Police Department, recently commended for saving lives in 2021, the Tenderloin officers alone helped save the lives of 124 people from overdose death using the Naloxone in 2020, but San Francisco lost 700 people to overdose death that year.

The Department of Public Works collects thousands of needles per year. The needle waste problem impacts everyone who tries to enjoy San Francisco's parks and playgrounds.

Similarly, San Francisco's park rangers have collected thousands of needles. They encounter numerous overdoses and are trained to and frequently administer Narcan.

San Francisco's Fire Department is also determined to save as many lives as possible.

In fact, they created a street overdose response team seven days a week whose job it is to go out on the city streets and find and revive people who have overdosed, people for whom there is no one to place a call to EMS. Who's ever even heard of that before? The fact that San Francisco needs such a team speaks volumes.

One thing, Your Honor, I want to make sure you don't misunderstand. We do not seek to ban opioids. We recognize their value.

Instead, we are seeking truth about the risks of opioids; and we are demanding that defendants comply with the Controlled Substances Act and the other applicable laws we've discussed.

In closing, I'd like to return to Patrick Radden Keefe's words cited by my colleague in opening (as read):

"The opioid crisis is, among other things, a parable about the awesome capability of private industry to subvert public institutions."

And while San Francisco struggled and continues to struggle to face the worst drug scourge it has ever faced, defendants made a mockery of the laws put in place to protect our communities from unfair marketing and diversion of controlled substances with their ultimate concern being first, last, and always to drive sales, make quota, and reach their goals.

And, finally, I'd just like to end with a last Teva sales video. It's called "Pain Lingers," and it certainly does here in San Francisco.

(Video was played but not reported.)

MS. BAIG: With that, Your Honor, I have nothing further. Thank you.

THE COURT: Okay. Thank you very much.

Well, defense wants to proceed tomorrow I assume, and that's fine at 9:30. I don't know where we've -- were you able to locate -- since I have some time, were you able to locate those documents from Walgreens?

MS. SWIFT: Kate Swift for Walgreens, Your Honor.

Yes. I have most of them. I was just informed that

there's an additional document that is not in my stack that is in the slide deck, but I have -- I have what you've requested.

THE COURT: Pardon me?

MS. SWIFT: I have what you have requested.

THE COURT: Great. Well, why don't you, if you will, give them -- show them to plaintiffs' counsel and then just hand them to Ms. Scott, and I'll take a look at them.

And if there's anything that needs to be supplemented, you may do so. I'll take a look at them.

(Pause in proceedings.)

THE COURT: Okay. And thank you very much.

Ladies and gentlemen, very interesting. And you probably won't hear a lot of comments out of me. And don't take anything I say indicative of any direction I'm going. It's not helpful to you. It may be helpful to me, I don't know, but it is not helpful.

I'm going to listen to the evidence.

Thank you very much. See you tomorrow morning.

(Proceedings adjourned at 2:29 p.m.)

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CERTIFICATE OF REPORTER

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: day , month date ,

Marla Knox

Marla F. Knox, CSR No. 14421, RPR, CRR, RMR
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